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ABSTRACT

The document establishes the minimum standards for program approval, pupil eligibility, and appropriate programing within the least restrictive environment as mandated by the Arkansas Act 102 of 1973, as amended by Act 641 of 1975 (the Handicapped Children's Act) and P.L. 94-142 (the Education for All Handicapped Children Act). Part 1, on program standards, begins with definitions of special education terminology. Individual sections address requirements for the least restrictive environment, teacher/pupil ratio, selection of special education facilities, related services required to assist a handicapped child to benefit from special education, testing and test evaluation, evaluation committee responsibilities, use of the time-out seclusion room, and eligibility for special education. Part 2 focuses on eligibility. Briefly described are the six steps for determining eligibility and the resulting program -- referral, screening, evaluation, analysis, eligibility, and programing. Outlined are the definition, possible referral characteristics, screening areas, required evaluation data, evaluation data analysis procedures, and programing considerations for each of 10 handicapping conditions: hearing impairment, mental retardation, multiple disabilities, orthopedic handicaps, other health impairments, serious emotional disturbances, severe/profound handicaps, specific learning disability, speech impairments, and visual handicaps. Part 3 consists of an appendix with footnotes, annotations of tests, a list of tests and publishers, and publisher addresses. (SW)

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Program Standards and Eligibility Criteria for Special Education

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GENERAL

The Arkansas State Board of Education gave tentative approval on June 9, 1975, and final approval on September 8, 1975, to the State Plan for Special Education. The State Plan for Special Education was designed to be the process which will be used within the schools of the State of Arkansas to implement Act 102 of 1973, as amended by Act 641 of 1975, the Handicapped Children's Act, and Public Law 94-142, the Education for all Handicapped Children Act of 1975.

This document entitled Program Standards and Eligibility Criteria for Special Education is a support document to the State Plan for Special Education. The purpose of this document is threefold:

1) to establish the minimum standards for program approval,
2) to establish the minimum standards for the determination of pupil eligibility, and
3) to establish considerations which will lead to appropriate programming within the least restrictive environment.

It is important for the user(s) of this document to note that minimum, not optimum, standards are being addressed. At any time a school district may establish criteria which exceed the standards stated herein; however, at no time may a school district establish criteria which are less than the standards stated.

The program standards are those considerations which are more closely related to guidelines for operating a program independent of the student per se. The eligibility criteria include the minimum criteria for the establishment of eligibility and are student-centered. In an attempt to distinguish between the program standards and eligibility criteria this document is divided into two sections:

1) general information for program standards and
2) criteria for eligibility for special education.

To achieve the stated purposes, the two sections must be used in conjunction with each other.

The reader will note that while the State Plan for Special Education addresses the education of handicapped students in terms of non- categorical services, the eligibility section and some references in the program standards section of this document are presented categorically. State and Federal laws require that a handicapping condition be established; consequently, a category of

exceptionality must be determined.

Categorization is the first essential step in determining the student's eligibility for special education services. The second step is the identification of an educational deficit as a result of the established handicap. It cannot be overly stressed that once eligibility for special education services has been determined through the process set forth by the Referral, Placement, and Appeal Procedures: Special Education and Related Services, programmatic categorization of the student and/or service is not necessary. It is important to further note that the services provided are dependent upon the educational needs of the student and not upon the categorization of the student.

The user(s) of this document should at all times follow the procedures described in Referral, Placement, and Appeal Procedures: Special Education and Related Services. To summarize, the procedures include: referral, referral conference, evaluation, evaluation conference, and individual education plan development. Due process should be followed in each of the stated steps with parental involvement and right to appeal afforded within each step of the process.

DEFINITIONS

In order to achieve clarity of the terminology used in this document, the following definitions are provided:

1) Itinerant Instruction

Instruction provided by a special education teacher to individual students removed from the classroom for intensive one-to-one instruction which may be academic or therapeutic. The instruction provided may be for short periods of time each day or for short periods of time on a rotating schedule.

2) Consulting Teacher
(referred to as resource consultant in State Plan for Special Education)

A special education teacher who has for his/her primary role that of consulting with regular and special education teachers regarding the modification and/or adaptations of instruction for specific handicapped students. The consulting teacher may provide limited direct instruction to the student. Basically, the student receives indirect instruction.

3) Resource Services

Instruction provided by the special education teacher to a student for a period(s) of time not to exceed fifty (50) per cent of the instructional day.

4) Special Class Services

Instruction provided by a special education teacher to a student which exceeds fifty (50) per cent of the instructional day.

5) Combination Resource/Special Class

This service setting is primarily one providing resource room services. However, because of the need for self-contained services on a very limited basis (usually one (1) to three (3) students), students may be self-contained within the resource room. Careful consideration must be given to the number of students receiving self-contained services within the resource room in order to ensure that both services are programmatically sound. (Funding adjustments will be made by the State Education Agency where the resource room teacher is state funded.)

6) Combination Special Class/Resource Room

This service setting is primarily one providing special class services. However, because of the need for resource room services on a limited basis (usually four (4) to five (5) students) students may receive resource room services within the special class. Careful consideration must be given to the number of students receiving resource room services within the special class in order to ensure that both services are programmatically sound.

7) Instructional Day

The instructional day is the amount of time spent in instructional activities excluding lunchroom, recess, and other activity periods.

8) Eligibility for Special Education Services

A student is determined eligible for special education services when a handicapping condition is present as defined in P.L. 94-142 that results in an educational deficit and the corresponding need for specially-designed instruction.

9) Special Education

Special Education means specially-designed instruction, at no cost to the parent, to meet the unique needs of a handicapped child.

10) Teacher Aide

A teacher aide is a person who works directly with school children and who is under direct supervision of a teacher or other certified professional school employee.

11) Qualified Examiner

There are five basic groups of persons who may administer some or all tests listed under the various categories of exceptionalities within part two of this document.

These include:

a) The certified teacher or counselor who may administer tests which do not require special training, certification or licensure; i.e., achievement tests.

b) The educational examiner, certified by the State Department of Education, who may administer intellectual, academic, behavior rating scales, and some language measures but may not administer tests which measure personality or psychiatric traits.

c) The psychological examiner, licensed by the Arkansas State Board of Examiners in Psychology. "A person practices as a "Psychological Examiner" within the meaning of this Act when he holds himself out to be a Psychological Examiner, or renders to individuals or to the public for remuneration any service involving the application of recognized principles, methods and procedures of the science and profession of psychology, such as interviewing or administering and interpreting tests of mental abilities, aptitudes, interests and personality characteristics, for such purposes as psychological evaluation or for educational or vocational selection, guidance or placement. The Psychological Examiner practices the following only under qualified supervision; over-all personality appraisal or classification, personality counseling, psychotherapy or personality readjustment techniques."[1]

d) The psychologist, licensed by the Arkansas State Board of Examiners in Psychology. "A person practices as a "Psychologist" within the meaning of this Act when he holds himself out to be a Psychologist, or renders to individuals or to the public for remuneration any service involving the application of recognized principles, methods and procedures of the science and profession of psychology, such as interviewing or administering and interpreting tests of mental abilities, aptitudes, interests and personality characteristics, for such purposes as psychological evaluation or for educational or vocational selection, guidance or placement, or for such purposes as over-all personality appraisal or classification, personality counseling, psycho-therapy or personality readjustment."[2]

e) The speech-language pathologist, either certified by the State Department of Education or licensed by the Arkansas Board of Examiners in Speech Pathology and Audiology, who may conduct assessments of auditory and communicative abilities functioning.

(See appendix - for test descriptions and lists of persons who can administer said tests.)

LEAST RESTRICTIVE ENVIRONMENT (L.R.E.)

Each school district shall insure that to the maximum extent appropriate, handicapped children are educated with children who are not handicapped, and that special classes, separate schooling or other removal of handicapped children from the regular educational environment occurs only when the nature of severity of the handicap is such that education in the regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.[3]

Determination of least restrictive environment should be made on an individual basis taking into account both service(s) needed and the program placement which would be most conducive for learning to occur. At all times the appropriate selection of an educational program determines the least restrictive environment.

The continuum model below shows both services and program options based on severity of handicapping condition. The chart should not be construed as the only way to determine the least restrictive environment.

Regular Class	Regular Class	Regular Class/ Resource Room	Some Instruction in Regular Class	No Instruction in Regular Class			
Indirect Service	Some Direct Instruction	Up to 50% of the Instructional Day in a Resource Room	Minimum of 50% of Instructional Day Self-contained	Special Day Service Facility	Residential School	Hospital Program	Homebound Instruction

Mild----------Severe/profound

(Degree of Handicapping Condition)

For service setting decisions and the resulting least restrictive environment, the following general factors should be taken into consideration:

1) Severity of the Disability

   In general, the more severe the handicapping condition, e.g. vision, hearing, intelligence, perception, etc., the more structure the program needs.

2) Achievement

   The degree to which a student is progressing relative to his peer group within the regular education program.

3) Success with Regular Program

   The portion of the regular education program in which the student is expected to make satisfactory progress.

4) Diagnostician Recommendation

The summary of information from the diagnostician(s) who has (have) conducted the educational evaluation of the student.

5) Evaluation Committee Recommendation

The evaluation committee has the responsibility to establish the primary handicapping condition of the student and the resulting educational deficit and to develop, based on all data, an individual educational plan (IEP) for the student. After the development of the IEP, the committee selects the most appropriate service(s) needed by the student in order to implement the IEP.

Service(s) provided to a student are subject to continual revision based on the student's progress or lack of progress in the service setting provided. Should the need for a change in the type of service be requested, the procedures described in the Referral, Placement, and Appeal Procedures: Special Education and Related Services must be followed. Changes cannot be made from one service setting to another service setting without following the referral and placement procedures.

The less restrictive the setting in which the student is receiving services, the more essential it is that there be continuity in the implementation of the individual education plan between the special education services and the regular classroom services. If it becomes evident that continuity of the individual education plan is not present and/or the less restrictive environment is impeding the student's progress, it then becomes necessary to consider a more restrictive environment (setting).

Hospital and/or homebound instruction is the instructional setting which is considered to be the most restrictive within the continuum of services in the least restrictive environment. For students receiving instruction within the hospital or homebound setting, the individual education program and subsequent placement must be reviewed every three (3) months.

To assist in determining that hospital and/or homebound instruction is the appropriate setting for the individual education program to be implemented, the following definition is offered:

> Any student 5 to 21 years of age who, because of the severity of or the nature and/or extent of his/her handicapping condition, requires homebound or hospital instruction shall have his/her individual education program implemented within his/her facility of confinement for as long as the handicapping condition prevents the student from safely and adequately attending school.

TEACHER/PUPIL RATIO

Refer to page three-one (3-1) to find considerations for determining amount and degree of severity.

Chart 1.A

MAXIMUM TEACHER/PUPIL RATIO

TYPE HANDICAP	ITINERANT INSTRUCTION	RESOURCE ROOM	SPECIAL CLASS MILD TO MOD.	SPECIAL CLASS MOD. TO SEVERE	SPECIAL CLASS SEVERE TO PROF.
HEARING IMPAIRED	1:20	1:15	N/A	1:10	1:8
MENTALLY RETARDED	N/A	1:30	1:15	1:10	N/A
MULTIHANDICAPPED	N/A	1:25	N/A	1:10	N/A
ORTHOPEDICALLY HANDICAPPED	1:25	1:20	N/A	1:10	N/A
OTHER HEALTH IMPAIRED	1:35	1:25	1:15	1:12	N/A
AUTISTIC	N/A	N/A	N/A	1:5	N/A
SERIOUSLY EMOTIONALLY DISTURBED	1:25	1:20	N/A	1:8	N/A
SEVERELY/PROFOUNDLY HANDICAPPED	N/A	N/A	N/A	N/A	1:5
SPECIFIC LEARNING DISABLED	N/A	1:30	1:15	1:10	N/A
SPEECH/LANGUAGE HANDICAP	1:50	N/A	N/A	N/A	N/A
VISUALLY HANDICAPPED	EL 1:12 Sec 1:20	1:8 1:15	N/A	N/A	1:5
NON-CATEGORICAL	1:35	1:25	1:15	1:12	N/A

When calculating the number of students being served, each student is counted one time. The following represents exceptions to the stated teacher/pupil caseload:

1) For each student receiving special class services within a resource setting the instructional load will be reduced by one student.

2) For each student receiving services for a moderate to severe speech and/or language disorder, the student will be counted as equivalent to three (3) mildly impaired students.

3) For each hearing impaired student receiving services on a non-categorical basis in a resource room setting, the student will be counted, for purposes of determining teacher/pupil ratio, as the equivalent of three (3). Maximum per period load when a hearing impaired student is receiving services should be reduced.

4) For each student receiving braille instruction on an itinerant basis, the instructional load of the vision teacher will be reduced by two (2) students.

With regard to itinerant instruction and resource room services of all types, a maximum of five (5) students per period will be the guideline. In those cases where scheduling does not permit an even flow of five (5) students per period, the number served should be as near to five (5) as possible. Exceptions to this guideline are:

1) Pre-vocational and vocational students who attend one class per day in the area of personal/social adjustment.

2) When the teacher has an aide to assist in follow- through activities, the per period load may be adjusted upward not to exceed 40% of the initial teacher/pupil ratio listed above. The teacher/pupil ratio per period should be reduced in number when the square footage of classroom space is insufficient.

At any time more than one exceptionality may be provided services within the same setting. For example: mildly handicapped students from more than one exceptionality may be served within the same service setting and moderate to severely handicapped students from more than one exceptionality may be served within the same service setting. To establish the teacher/pupil case load for services to more than one exceptionality, refer to chart (1.A) non-categorical.

FACILITIES

When planning the special education program, the following should be utilized when selecting the facilities for use in the special education program.

Self-Contained Classroom - The special education self-contained room should be at least 900 square feet in area as a variety of arrangements and furnishings are needed. The nature of the program should be considered in locating and/or designing the room. Toilet areas should conform to American National Standards Institute specifications for the accessibility of physically handicapped students. There should be a minimum of 100 square feet of storage space, part of which needs to be enclosed. A sink with hot and cold water as well as a work counter are recommended for the elementary level, self-contained classroom.

Resource Room - New construction of a special education resource room, in order to provide for flexibility in present and future programming, should be a minimum of 900 square feet of floor space.

Speech Therapy Room - Speech therapy rooms, in order to provide for flexibility in present and future programming, should be a minimum of 60 square feet of floor space per student served, which includes space for storage. A small chalkboard and bulletin board, as well as a long mirror, are also required. Such a room should be located in an area with a minimum of noise. Modifications to reduce the noise level should be considered when a room cannot be relocated.

Occupational and Physical Therapy Room - The size of these rooms shall be dictated by the activities to be carried on in these rooms.

Temporary facilities may be approved with a minimum of 60 square feet per student served, plus a minimum of 100 square feet for storage.

Architectural Barriers* - Those that limit student access to a special education program must be eliminated. School districts planning special education facilities and/or the elimination of architectural barriers in existing facilities should refer to the American National Standards Institute's specifications for making buildings and facilities accessible to and useable by physically handicapped people, A.N.S.I. A117.1-1977.

The above information is an excerpt from the addendum to the booklet, Guidelines for Planning School

Facilities, 1975, Arkansas Department of Education.

* With regard to architectural barriers, the Arkansas Department of Education will be referring to Section 504 of the Rehabilitation Act of 1973, Public Law 93-112.

RELATED SERVICES

Related services means transportation and such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education.[4]

The chart below categorizes both handicapping conditions and the typical related services that are most often necessary to meet the needs of students exhibiting these specific handicapping conditions.

Chart 1.B

	MR	SLD	OH	OHI	SI	VI	HH	Dea f	SED	MH	SPH
Counseling and Therapy					X		X	X	X		X
Medical Services (Diagnostic Only)			X	X	X		X	X	X	X	X
Occupational Therapy			X			X				X	X
Physical Therapy			X			X				X	X
Specialized Equipment			X			X	X	X		X	X
Specialized Transportation				(where necessary)					X		X
Educational Aides	X		X			X			X	X	X
Psychological Services	X	X	X	X	X	X	X	X	X	X	X
Specialized Materials	X	X			X	X	X	X	X	X	X
Inservice	X	X	X	X	X	X	X	X	X	X	X
Curriculum Development	X	X	X	X	X	X	X	X	X	X	X
Orientation/Mobility						X					X
Interpreter Services							X	X		X	X

Students are treated on an individual basis and selection of needed related services should be determined individually. The chart in no way attempts to limit or require that related services be provided to specific handicapping conditions, but is a guide which allows one to select the appropriate related services necessary for a student to benefit from special education.

At this time it should be emphasized that related services do not stand alone. Related services, by definition, are services required to assist a handicapped child to benefit from special education. With the exception of special transportation, no handicapped student may receive related services without also receiving "special education."

TESTING AND TEST SELECTION

Public Law 94-142 regulations address evaluation procedures in the following manner.

State and local educational agencies shall insure, at a minimum, that:

(a) Tests and other evaluation materials:

(1) are provided and administered in the child's native language or other mode of communication, unless it is clearly not feasible to do so;

(2) have been validated for the specific purpose for which they are used; and

(3) are administered by trained personnel in conformance with the instructions provided by their producer;

(b) Tests and other evaluation materials include those tailored to assess specific areas of educational need and not merely those which are designed to provide a single general intelligence quotient;

(c) Tests are selected and administered so as best to ensure that when a test is administered to a child with impaired sensory, manual, or speaking skills, the test results accurately reflect the child's aptitude or achievement level or whatever other factors the test purports to measure, rather than reflecting the child's impaired sensory, manual, or speaking skills (except where those skills are the factors which the test purports to measure);

(d) No single procedure is used as the sole criterion for determining an appropriate educational program for a child; and

(e) The evaluation is made by a multi-disciplinary team or group of persons, including at least one teacher or other specialist with knowledge in the area of suspected disability.

(f) The child is assessed in all areas related to the suspected disability, including, where appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status and motor abilities.[5]

The required minimum components of comprehensive evaluations are addressed within each category of exceptionality in the eligibility section of this document. At any time a qualified examiner may utilize tests that are not listed, but are equivalent to those listed. When the examiner chooses to utilize a test not listed the following considerations should be made in determining the equivalency of the tests: reliability, validity, norming, procedures for administration, and age ranges. In accordance with the regulations stated above, some tests can be administered by the classroom teacher (See Appendix).

The following are criteria in non-discriminatory testing:

1) selection of tests made on an individual basis,

2) utilization of native language,

3) utilization of adaptive behavior scales,

4) adaptation of testing procedures for sensory or motor impaired students,

5) utilization of more than one test,

6) utilization of tests that not only compare the student to other students but also compare the student to himself.

It should be noted that if schools use the tests, evaluation components, and definitions set forth in this document then the requirements for testing stated in the regulations for Public Law 94-142 will be met in most cases.

When specialized evaluations are needed beyond the parameters of educational assessment, the evaluators will adhere to the rules, regulations, and laws of the State of Arkansas as they apply to each specialized group of evaluators. The rules, regulations, and laws governing specific groups of evaluators contain provisions under which students either pursuing licensure or as part of their field of study may evaluate students. Prior to the use of students as evaluators, it is advised that district personnel become familiar with the applicable rules, regulations and laws.

With regard to the use of student evaluators as a part of the evaluation team determining the eligibility of students for special education, the Arkansas Department of Education, Special Education Section, has established the following guidelines:

1) The informed consent form signed by the parent/guardian must indicate the use of a student evaluator.

2) The report must indicate that the evaluation was administered by a student evaluator.

3) The student evaluator must sign the report.

4) The supervisor of the student evaluator must sign the report.

5) Student evaluator must abide by the rules, regulations, and laws that pertain to the area of licensure or field of study which the student is pursuing.

EVALUATION COMMITTEE RESPONSIBILITIES

Evaluation committee members* have the responsibility for (1) establishing the primary handicap of the student, (2) determining the adverse affect on educational performance and (3) the resulting need for special education services. It is recommended that these items be clearly stated in the evaluation conference decision and that the statement of primary handicap be signed by the chairman of the evaluation conference committee.

For students suspected of being seriously emotionally disturbed, it is required that clinical diagnosis be made by either a licensed psychologist or psychiatrist. It then becomes the responsibility of the evaluation committee to determine whether an educational handicap exists and the corresponding need for special education services. Clinical diagnosis alone does not automatically pre-determine the need for special education services. Decisions related to educational programming and placement are the sole responsibility of the evaluation committee.

To achieve the maximum multi-disciplinary team approach, it may be necessary for districts to define the roles of each of the team members in the data gathering process.

To implement the concept of the multi-disciplinary team, it is necessary for more than one person to contribute data (both formal and informal) relative to the student's comprehensive evaluation. As previously stated, the minimum components of the comprehensive evaluation include an intellectual, academic, adaptive behavior and communicative abilities assessments. In addition to the minimum components of the comprehensive evaluation, hearing and vision screening and social history are required data to be gathered.

It is not uncommon for as many as five or six persons to contribute data that will be considered at the evaluation conference. It is desirable that data to be utilized as components of the comprehensive evaluation, and not administered by the evaluator conducting the intellectual assessment, be completed and available to the evaluator prior to the intellectual assessment. It is recommended that the evaluator (assessing intellectual) include all data, hearing and vision screening, social history, etc., within the evaluation report.

The evaluator may request to do additional testing when test results from various sources appear to be contradictory or inadequate.

Consideration must be given to whether the data substantiates the existence of a handicapping condition. It is also imperative that evaluation committees assess the socio-cultural background of the student and the relationship that it has to formal test data. All information gathered should be considered as to how each component relates to the total school performance of the student.

In addition to comments stated in the discussion on the evaluation committee's role, for students categorized as specific learning disabled the evaluation team shall prepare a written report of the results of the evaluation. The report must include a statement of:

1) whether the child has a specific learning disability;
(statement of primary handicapping condition)

2) the basis for making the determination;
(list of tests and other evaluative methods and reasons for the decision)

3) the relevant behavior noted during the observation of the child;
(statement from the observing party)

4) the relationship of that behavior to the child's academic functioning;
(severe discrepancy with evaluative and supportive data)

5) the educationally relevant medical findings, if any;

6) whether there is a severe discrepancy between achievement and ability which is not correctable without special education and related services; and

7) the determination of the team concerning the effects of environmental, cultural or economic disadvantage.

Each team member shall certify in writing whether the report reflects his or her conclusion. If it does not reflect his or her conclusion, the team member must submit a separate statement presenting his or her conclusions.[6]

* In accordance with Referral, Placement and Appeal Procedures: Special Education and Related Services, evaluation committee includes the parent or guardian of the student.

USE OF TIME-OUT SECLUSION ROOM

The Arkansas Department of Education recognizes time-out as the removal of the opportunity to engage in reinforced behavior. As such the time-out seclusion room is an extension of such techniques as turning a chair away from a group or placing a child in the corner or the hallway. Time-out is only effective "if the classroom environment from which the child is removed is more reinforcing than the isolation area in which he is placed."

Restrictions on the use of a Time-Out Seclusion Room

1. Time-out seclusion should be used only for behaviors that are destructive to property, aggressive to others, or severely disruptive to the class environment. General non-compliance, self-stimulation, academic refusal, etc. can be responded to with less stringent and restrictive techniques.

2. The time-out room should be used only as a last resort if and when less restrictive means of controlling behavior have proven ineffective.

3. The necessity of using physical force to place a student in a time-out room beyond that reasonably managed by the teacher is inappropriate in a public school classroom. Involuntary time-out must not be used with such students, and in general, time-out is not an appropriate intervention for classroom use with any students older than 12 unless they have made a contractual agreement for its use.

4. Time-out rooms must meet structural guidelines and provide an adult the means of continously monitoring, visually and auditorially, the students' behavior. (See page 9-4)

GUIDELINES FOR APPROPRIATE USE OF TIME-OUT SECLUSION ROOM

1. The teacher or behavioral specialist should have documentation that milder forms of time-out or other reduction techniques have proven ineffective in suppressing the inappropriate behavior.

2. The use of seclusion time-out should be included in the student's individual education program (IEP). Parent permission for the time-out seclusion procedure should be secured at the time the procedure is discussed.

3. The behaviors which will result in use of the time-out room must be explicitly stated in the child's IEP.

4. Time-out must be paired with a plan to provide positive reinforcement for appropriate behaviors. This must also be included in the child's IEP. A cardinal rule in the use of time-out is that a corresponding effort should be made by the teachers to increase their level of positive interaction with the child when he/she is behaving appropriately, particularly during the time the seclusion program is in effect.

5. A concise written statement of procedures to be followed whenever placing a student in time-out should be prepared as a classroom guide and individualized for each student for whom a time-out seclusion program is to be used.

   The following guidelines should be adhered to for effective use of the time-out seclusion room:

   a. Avoid lengthy verbal explanations as to why the student is being placed in the time-out room. Behaviors resulting in time-out should be clearly explained prior to implementing the time-out program. If an explanation is provided during use of this technique, it should be brief but should adequately inform the student of the misbehavior involved. A standard explanation format such as, "Because you _____, you go to time-out for _____ minutes," is recommended. All other interaction should be avoided.

   b. To maximize opportunities to exercise self control, students should be given the opportunity to take their own time-out after receiving the instruction from the teacher. However, if students refuse to take their own time-out or if they fail to

respond to the teacher's instructions within a reasonable time interval (5 to 10 seconds), the teacher should physically remove them to the time-out area. For high intensity behavior (e.g., kicking, screaming), the student should be immediately escorted to the time-out room. It is important that teachers realistically evaluate their ability to physically remove a child to the time-out room. If there is a reasonable doubt concerning the capability of the teacher to physically remove the resistant student, the teacher should not even begin to attempt the time-out procedure. Presumably, classrooms with such students would either have a teacher or teacher aide who could control such resistance. If such is not the case, an alternative strategy will be required. This may entail a reevaluation of the reinforcers in the classroom and the possible use of a response cost contingency in conjunction with a token economy. Other alternatives may include reinforcing other children for ignoring disruptive behaviors or the reassignment of the uncontrollable student to a teacher who is capable of managing his behavior.

c. Length of time spent in the time-out seclusion room must be kept within limits:

i. No more than 5 minutes each exclusion - pre-school

ii. No more than 15 minutes each exclusion - lower elementary

iii. No more than 20 minutes each exclusion - middle & upper elementary.

At the end of the prescribed time, the child should be offered the opportunity to rejoin the class. If the student chooses to stay in the time out room, the door must be left open at this time. When a student consistently chooses to stay in the time-out seclusion room beyond the prescribed length of time, the teacher and evaluation committee may need to examine the use of the procedure. The time-out room may be providing more reinforcement than the environment from which the child was removed.

iv. Should there be a need for a time-out period to extend past these limits, a professional colleague should be immediately called in to help evaluate the appropriateness of continuing the time-out procedure. This may be the principal, counselor, an ED team member, or another support staff person in the building. Careful consideration must be taken in extending the prescribed lengths of the time-out seclusion. The effectiveness of the time-out procedure is the result of its consistent use for behaviors specified in the student's IEP rather than the length of stay in the time-out seclusion room.

6. Records should be kept of each occasion when seclusion time-out is used. The records should include:

a. Student's name.
b. Behavior as specified in IEP for which time-out is being used.
c. The time of day the student was placed in and released from time-out.

7. The use of the time-out seclusion procedure shall be altered or discontinued as a behavioral change technique if data do not support its effectiveness. An advisory committee consisting of the teacher, principal, ED team member, and parent should be called in to evaluate the appropriateness of using time-out as a consequence for misbehavior if its effect in suppressing the behavior is questionable.

8. If a time-out room is to be employed, the time-out room should:

a. Be at least 4' X 4' and no larger than 6' X 6' in size.
b. Be properly lighted (preferably recessed, with the switch outside the room). Lighting should remain on at all times.
c. Be properly ventilated.
d. Be free of objects and fixtures.
e. Provide the means by which an adult can continuously monitor, visually and auditorially, the student's behavior.
f. The door should be such that it cannot be locked.
g. Meet State and County fire and safety codes.

9. When a prescription for seclusion time-out is written, it is recommended that the student's program be examined for appropriateness twice monthly. This review is encouraged because the need for this type of behavioral intervention could indicate that behavioral objectives, techniques, or other factors affecting the learning environment are not appropriately matched with the student's needs and behaviors.

In addition, it is recommended that all personnel involved in designing and implementing behavioral management procedures be adequately trained and monitored in such procedures. It is imperative that these persons have attained levels of skill and competency so that their qualifications correlate with their responsibilities.

ELIGIBILITY FOR SPECIAL EDUCATION

The Program Standards section of this document has spoken to those considerations relative to program operation. The next section of this document addresses eligibility for special education. The eligibility section is divided into various primary handicapping conditions; however, it should be noted that the presence of a handicapping condition alone is not sufficient for eligibility for special education. The handicapping condition must result in an educational deficit and the corresponding need for specially designed instruction.

It is essential that the user of this document be aware of the steps in the determination of eligibility for special education as the required and recommended testing in the next section is only one facet in the determination. The completion of the required testing does not automatically imply the completion of eligibility requirements.

Two handicapping conditions present a major concern in the establishment of an educational deficit and the corresponding need for specially-designed instruction. These two handicaps are orthopedically handicapped and other health impaired. For example: a student in a wheelchair may or may not have an educational deficit as a result of his/her orthopedic handicap which warrants a need for specially-designed instruction. However, this same student may also be mentally retarded, specific learning disabled, etc., which results in an adverse affect on his educational performance and the corresponding need for special education services. In most cases where an educational deficit exists as a result of a student being either orthopedically handicapped or other health impaired there is also the presence of another handicapping condition. The presence of another handicapping condition may in reality be the actual primary handicapping condition rather than orthopedically handicapped or other health impaired being the primary handicapping condition.

ELIGIBILITY: IDENTIFICATION, EVALUATION, AND PROGRAMMING

Establishing eligibility is a component central to program standards, as special education can be provided only when a child has been determined as being eligible for these services. A child is determined eligible when the child has been evaluated in accordance with state and federal regulations and has been determined to be mentally retarded, hearing impaired, speech/language handicapped, visually handicapped, seriously emotionally disturbed, orthopedically handicapped, other health impaired, deaf-blind, multi-handicapped, severely/profoundly handicapped, or to have specific learning disabilities, and who because of those impairments and the adverse affect on his/her educational performance is determined eligible for special education and related services. Once eligibility has been established, a program is designed which meets the individual needs of the student. The sequence which is followed in determining eligibility and the resulting program is presented in Figure 1. Six steps are presented in this sequence. These steps include:

1. Referral
2. Screening
3. Evaluation
4. Analysis
5. Eligibility
6. Programming

Each of these steps is explained in further detail in the following pages.

REFERRAL

The first step in determining eligibility for Special Education services is the referral. A referral is made when a student is identified as experiencing learning and/or adjustment problems. Parents, teachers, counselors, school nurses, principals and others having direct contact with this student can initiate the referral. Intellectual, academic, behavioral, communicative and physical characteristics which may be indicators of possible difficulties, which lead to referral, are listed within each handicapping category of this handbook. The referral is made for the purpose of compiling information regarding the student encountering difficulties in the regular education program. Referral, Placement, and Appeal Procedures: Special Education and Related Services outlines the referral process which must be followed.

SCREENING

Screening is defined as the data gathering process which includes basic tests administered to or procedures used with all children in a school, grade, or class.

Screening serves a two-fold purpose. First, screening is used to ascertain, in a global means, current levels of functioning and to assess the extent of a student's skill development. The second purpose of screening is to determine the need for more indepth assessment and analysis. Any student whose performance, on a screening instrument or group of instruments, indicates a possible learning or adjustment problem is referred for an evaluation - comprehensive or specialized. The model utilized in this handbook delineates two levels of screening - required and recommended. Within the recommended section both formal and informal procedures are presented.

Required:

Hearing tests and vision tests are administered to identify students who may possess a visual and/or auditory acuity problem. Unless the primary handicapping condition is other than that of hearing or vision there is little reason to continue the eligibility process. If hearing or vision is the basis for eligibility, then appropriate procedures are implemented to serve the students through special education.

Recommended:

Formal - Formal is used here to indicate standardized, published tests. Specific test are administered so the teacher may acquire additional information upon which to make a detailed analysis of the student's level of functioning and the need for more detailed investigation. The selection of the formal tests should involve careful planning. The individual responsible for administering the test should be aware of the specific purpose of the test and how the information obtained from the test will be used. Instruments which can be used are listed within each handicapping category in this handbook.

Informal - Informal procedures are used when specific data are not available from formal procedures or to supplement information obtained from standardized tests. Informal procedures which can be utilized include:

- teacher-made tests to assess a wide variety of both specific and broad range skills; i.e., assessment of skills in addition or assessment of the entire area of arithmetic
- checklists
- self-rating devices
- inventories - behavior, interest, personality traits
- rating scales
- anecdotal records
- interviews
- sociometric technique
- observation

- ID and PP - Informal Diagnosis and Prescriptive Programming is a training program designed to assist individuals in being able to informally gather information which is necessary for appropriate program planning. Components include: (1) defining the problem and identifying what will meet the student's needs, (2) task analysis, (3) error pattern analysis, (4) systematic inquiry, (5) discovering what skills a child can and cannot do, (6) setting priorities for children, (7) writing instructional objectives, (8) learning methods, (9) matching learner characteristics with material characteristics, and (10) designing materials for the educationally handicapped. ID and PP training sessions have been conducted across the State. For further information contact an Area Supervisor from the Special Education Section.

EVALUATION

Evaluation is defined as the data gathering process where procedures are used selectively with an individual child. It does not include basic tests administered to or procedures used with all children in a school, grade, or class.

Once the screening process has been completed and evidence of more analysis is needed, evaluation data is gathered. The purpose of this process is for determining eligibility and any resulting educational deficit. Also gathered during this process is data used in planning programs and services needed to meet the needs of the student. Procedures which must be followed are outlined in Referral, Placement, and Appeal Procedures: Special Education and Related Services.

Social History:

The first section relates to the development of a social history of the student. This should include pertinent information about the student's educational history. Most of this information can be obtained from the cumulative school records and other agencies from which the student has obtained services. The family history will be obtained from an interview with the parents or legal guardian. A medical history is obtained from school records, family information, and reports from other agencies.

Assessment:

The components of the assessment section will result in a comprehensive evaluation. Components include intellectual, achievement, adaptive behavior, communicative abilities, and other pertinent sources of information. Data gathered from these sources provide information regarding the total functioning of the student.

Intelligence - An individualized intelligence test which is appropriate to the age level of the student must be administered by a certified educational examiner, licensed psychologist, or licensed psychological examiner.

Achievement - These tests directly assess a student's skill development in academic content areas. They measure the level of academic skill attainment or educational achievement.

Adaptive Behavior - Adaptive behavior refers to the manner in which an individual copes in independent functioning, personal responsibility, and social responsibility.

Communicative Abilities - These tests determine levels of functioning in regard to speech (fluency, voice, articulation), language and hearing processes. This includes abnormal comprehension and/or expression of spoken or written language.

Other - Pertinent information needed to determine a student's specific strengths and weaknesses in a particular area are provided in this section.

ANALYSIS

After the assessment has been completed the next step in the process is the interpretation of the assessment data. This requires that the information from the assessment be analyzed for indicators of learning and/or adjustment problems. Information gathered in this segment of the process is probably the most crucial in the analysis of a student's performance and in determining special education eligibility.

ELIGIBILITY

To be eligible for special education the student must have an identified handicap which results in an educational deficit and the corresponding need for special education.

PROGRAMMING

The last step in the process is the development of an educational program based upon the data obtained from the evaluation. Data received from the evaluation segment will provide information concerning the student's intellectual ability, where the student is performing in the different skill areas, and what the student's particular strengths and weaknesses are. An analysis of this information will assist in the planning of an educational program. The information obtained can also be applied to instructional strategies which can be implemented.

The Programming Recommendations section of this handbook provides guidelines which can be used for programming in each category of handicapping condition.

Informal Diagnosis and Prescriptive Programming (ID & PP) is a program which will assist the classroom teacher in making program decisions. For more information regarding ID and PP, refer to the previous section on informal screening.

HEARING IMPAIRED
(Deaf and Hard of Hearing)

I. DEFINITIONS

A. "Deaf" means a hearing impairment which is so severe that the child is impaired in processing linguistic information through hearing with or without amplification, which adversely affects educational performance.

B. "Hard of Hearing" means a hearing impairment, whether permanent or fluctuating, which adversely affects a child's educational performance but which is not included under the definition of "deaf."[7]

1. "Fluctuating Hearing Loss" -- the child with a fluctuating hearing impairment, such as one resulting from chronic otitis media, is classified as hearing impaired.

2. Unilateral Hearing Loss -- the child with a hearing loss in one ear would not be classified as handicapped under the category of hearing impaired. A referral conference activity should be held concerning this child to designate any program modifications and to specify participation in an annual hearing screening program.

II. POSSIBLE REFERRAL CHARACTERISTICS

A. Intellectual:

The range of intellectual functioning follows that of the normal population. When reviewing the Wechsler Scale results, the possibility of hearing impairment should be considered in the event of a significantly weaker verbal IQ score.

B. Academic:

- has poor reading comprehension skills
- has poor word attack skills
- has difficulty with abstract concepts (may be able to think in abstract terms, but unable to express the concept)

C. Behavior:

- frequently uses "neutral response", "smiling", saying "yes" and periodically nodding in situations where he lacks understanding
- has difficulty following verbal directions or does not respond
- frequently asks to have statements repeated
- may appear hyperactive as he is dependent upon monitoring the environment visually and tactually
- is inattentive in group activities
- appears to be confused, especially in noisy situations
- tends to be "on-guard" more than usual if he feels inadequate
- gives inappropriate answers to simple questions
- may isolate himself or be isolated by his peer group
- has complete or partial misunderstanding of conversation
- is overly dependent on visual clues
- may have a low tolerance for frustration
- often speaks too loudly or too softly

D. Communicative Abilities:

1. Language:

- spoken and/or written language compares poorly with peer group
- has difficulty expressing ideas
- spoken and/or written words omitted from sentences or word order may simply be unintelligible, i.e., "Finished home" for "When he was finished, he went home"
- figurative and abstract patterns of spoken and/or written language including idioms, metaphors, similes and personifications neither used nor understood
- limited vocabulary
- incorrect sentence structure
- difficulty following oral and written directions

2. Speech:

- voice quality harsh, breathy, nasal, and/or monotone
- sounds distorted and/or omitted from words, i.e., "I caught a fish" may be spoken or written as "I cau-fi-"
- may drop plural and possessive endings, i.e., he says "The boy hat" for "The boy's hat"
- pitch, rhythm, stress, inflection and/or volume are inappropriate

3. Auditory:

- turns head to one side to hear better
- has difficulty in locating source of sounds or speech
- responds better to environmental noises than to voice
- has problems understanding speech after cold subsides
- poor ability to hear or discriminate between environmental and/or speech sounds

E. Physical/Medical:

- history of frequent earaches or ear discharge, or nasal obstruction with associated mouth breathing or other nasal symptoms
- frequent colds, sneezing, earaches, allergies, history of viral infections, high fever, etc.
- family history of hearing loss and/or ear disease
- history of dizziness and balance problems
- deformity of the outer ear

III. IDENTIFICATION: HEARING SCREENING AND FOLLOW-UP

Approximately 5% of school-age children fail hearing screenings and as many as one-third of this number may actually have some degree of hearing loss.[8] To aid in identifying these students,each school should undertake a hearing screening program to be conducted at least annually by trained personnel. (If screening assistance is required, contact the Special Education Section or the Arkansas Department of Health/Hearing and Vision Services.) The

minimum population to be screened should include the following:

1) Grades K, 1, 3, 5, 7
2) Students now receiving special education services
3) New students
4) Students with identified unilateral losses
5) Teacher referrals
6) Students who failed previous hearing screening

Students who fail the initial screening should be rescreened within a four- to six-week period. Failure of the second screening constitutes an automatic referral, to be made by the principal or designee.

Prior to the referral conference, informal classroom observation should be conducted, taking into consideration the referral characteristics listed in Section II. The Area Specialist for the Hearing Impaired can provide assistance in this area.

If the referral conference decision is that the student is not experiencing difficulties in the classroom, the conference decision form should reflect that evaluation by the school is not necessary at this time, but that the student will be screened annually. At this point, even though any possible hearing loss is not educationally significant, the school should encourage parents to arrange for a medical examination.

If the referral conference decision is that the student is experiencing difficulties in the classroom, the school is required to provide for evaluation activities. In addition to the required evaluations, an otological examination is needed for students with a history of frequent ear infections.

IV. SCREENING INFORMATION

A. Required:

- hearing
- vision

B. Recommended: Either/or a combination of formal and informal data

1. Formal
   - not applicable
2. Informal
   - observation
   - checklist
   - anecdotal records

V. REQUIRED EVALUATION DATA

A. Social History:

1. Education

2. Family (using language of the home, includes American Sign Language)

3. Medical

B. Assessment:

1. Individual intelligence (required initially and at least every three years thereafter or more frequently upon referral)

- Hiskey Nebraska Test of Learning Aptitude (ages 3-18 1/2 years)

- Leiter International Performance Scale - Arthur Adaptation (ages 3-18 years)

- Wechsler Intelligence Scales (performance) (ages 6-16 years)

The verbal scale may be administered as a measure of language functioning but should not be interpreted as an indicator of intellectual capacity. (Verbal Scale or Full Scale I.Q.)

2. Individual achievement test (one required)

- Peabody Individual Achievement Test (PIAT) (grades K-12)

- Stanford Achievement Test - Hearing Impaired Norms (ages 8 - 21 years)

- Wide Range Achievement Test (WRAT) (grades K-12)

3. Adaptive Behavior (one required)

- Burk's Behavior Rating Scale (grades 1-9)

- Meadow/Kendall Social-Emotional Assessment Inventory for Deaf Students (ages 7-21 years)

- Vineland Social Maturity Scale (ages 0-30 years)

4. Visual Motor Perception

a. Visual Perception (one required)

- Bender Visual-Motor Gestalt Test (ages 4-11 years)

- Developmental Test of Visual-Motor Integration (ages 2-15 years)

- Frostig Developmental Test of Visual Perception (ages 4-8 years)

- Goodenough-Harris Draw-A-Man Test (ages 3-15 years)

b. Motor Development

- Oseretsky Test of Motor Proficiency (ages 4-18 years)

- Purdue Perceptual/Motor Survey (grades 1-4)

5. Communicative Abilities

a. Language (both receptive (R) and expressive (E) language assessments are required. For the hearing impaired child, I.Q. scores should not be computed from language evaluations.)

- Bankston Language Screening Inventory (ages 4-7 years)

- Carrow Test for Auditory Comprehension of Language (R) (ages 2-6 and 6-11 years)

- Grammatical Analysis of Elicited Language (E) (ages 8-12 years)

- Illinois Test of Psycholinguistic Abilities (useful programming tool) (R) (ages 2.4 - 10.3 years)

- Peabody Picture Vocabulary Test (R) (ages 2.3 - 18.5 years)

- SKI-HI Language Development Scale (R & E) (Infancy to 5 years)

- SKI-HI Receptive Language Test (R)

- Spontaneous Language Sample (two or three settings) (E) (all ages)

- Test of Language Development (R & E) (ages 4-8.11 years)

- Test of Syntactic Ability (E) (ages 10-18 years)

- Total Communication Receptive Vocabulary Test (R) (ages 3-12 years)

- Utah Test of Language Development (R & E) (ages 1-15 years)

- Verbal Language Development Scale (R & E) (ages 1-16)

b. Speech (one required)

- Goldman-Fristoe-Woodcock Test of Articulation (ages 3 - adult)

- Ling Phonetic Speech Evaluation (infancy to adult)

c. Auditory (one required)

- Informal Assessment of Auditory Levels (alerting, localization, distance, levels, gross environmental discrimination, gross vocal discrimination, and fine speech discrimination) is highly recommended. A detailed explanation of each level can be found in the Project SKI-HI Home Intervention Manual.

- Pittsburgh Auditory Test (Subtests 1-5a)

- Test of Auditory Comprehension (ages 2-11 years)

d. Lipreading

- Craig Lipreading Inventory

6. Vocational (recommended during the sophomore and senior years of high school)

- Becker Reading-Free Vocational Interest Inventory (high school level)

- Geist Picture Interest Inventory (grades 8-12)

- Self Directed Search (ages 15 and older)

- Wide Range Interest-Opinion Test (ages 5 - 35 years)

7. Audiological

a. Audiometric assessment by an ASHA certified audiologist (required annually or when deemed necessary by the managing audiologist)

(1) Puretone

- air conduction

- bone conduction

(2) Speech audiometry

(3) Hearing aid evaluation to include electroacoustic assessment of hearing aid function, as well as evaluation of aided hearing response and determination of appropriateness of the hearing aid

(4) Impedance audiometry including tympanometry and stapedial reflex testing.

b. Categories of Hearing Loss

Normal	0 - 20dB
Mild	21dB - 40dB
Moderate	41dB - 55dB
Moderately-Severe	56dB - 70dB
Severe	71dB - 90dB
Profound	90 and greater

c. Amplification Systems

A special effort should be made to insure that amplification systems worn by the child in school are functioning properly. Proper maintenance includes a daily listening check with emphasis on the following:

1. Ear molds (young children may require new ear molds every six months)
2. Batteries (should be checked at the beginning of each day)
3. Cords
4. Receivers

Please Note: FM amplification systems should be purchased only on a recommendation from the managing audiologist.

8. Reading

- Botel Reading Inventory
- Diagnostic Reading Test
- Durrell Analysis of Reading Difficulty
- Gates-McKillop Reading Diagnostic Test
- Gilmore Reading Test
- Gray Oral Reading Test
- Woodcock Reading Mastery Test

9. Arithmetic

- Diagnostic Chart for Fundamental Processes in Arithmetic
- Diagnostic Tests and Self-Helps in Arithmetic
- Key Math Diagnostic Arithmetic Test
- Stanford Diagnostic Arithmetic Test

VI. EVALUATION DATA ANALYSIS

Some students who are deaf or hard of hearing will require special education services because their hearing impairment adversely affects their educational performance. The following are recommendations to consider when analyzing evaluation data:

A. A special effort should be made to differentiate between speech and language concerning the hearing impaired child. For example, speech intelligibility is not an indication of

language or intellectual abilities.

B. Information provided by parents of hearing impaired children is necessary in the analysis of evaluation data.

C. All tests should be administered in the child's primary mode of communication, i.e., sign language, fingerspelling, cued speech.

VII. PROGRAMMING CONSIDERATIONS

The following guidelines should be observed for the hearing impaired child in the classroom:

A. Classroom Management Techniques

- The communication mode used in the classroom should be appropriate to each child's needs.
- Learn the extent and nature of the hearing loss.
- Conduct a daily hearing aid listening check.
- Allow the child to sit as close as possible to the source of sound.
- Classroom noise should be kept at a minimum.
- Speak naturally and in complete sentences.
- Discretion should be used when considering auditory teaching aids
- Be aware of additional hearing loss caused by colds, sore throats, or earaches
- Make sure the child is attentive. Ask open ended questions pertinent to the subject to be sure he is alert to the content.
- Visual aids should be used whenever feasible.
- Encourage a "buddy system." This is advantageous in many subjects and activities.
- Assignments should be written on the board.
- Lessons should be outlined on the board.
- The class should be provided with supplemental written materials.
- When speaking stand still and do not put obstacles in front of face.
- Encourage hearing children not to mumble, but rather speak clearly and distinctly.
- Be patient when the hearing impaired child asks you to repeat.
- Do not ask the hearing impaired child to memorize long lists of items presented orally.
- Discussion groups may create problems for hearing impaired students.
  a. Use small groups instead of one large group.
  b. Provide face contact for lipreading, have the group sit in a circle.
  c. Have only one person in the group talking at any one time.
  d. Write on the blackboard the main points which each speaker contributes.
  e. Encourage the student to ask questions and participate in group discussions.

B. Social Considerations

1. Provide hearing students with general and useful information concerning hearing, hearing loss, amplification devices and communication modes. Mini-courses may be instrumental in utilizing Area Specialists for the Hearing Impaired and hearing aid users to familiarize classmates with the equipment.

2. Encourage the hearing impaired child to participate in regularly scheduled and extracurricular activities.

3. Hearing impaired adults can provide a positive role model for the hearing impaired child and information for his/her classmates.

C. Speech

1. Voiceless sounds such as "s". "t". "h", "f", and "th" are difficult for the hearing impaired to hear. Problems are caused by sounds which are not clearly visible on the lips, such as "k", "g", and "ng". The hearing impaired child's speech is often affected because the child does not see and/or hear many sounds, and may omit, mispronounce or substitute other sounds.

2. The hearing impaired child's voice may sound abnormal.

3. Hearing loss affects rhythm, intonation, and inflection patterns.

4. The regular classroom teacher and the speech therapist should work closely together to reinforce good speech skills at all times.

I. DEFINITION

"Mentally Retarded" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period, which adversely affects a child's educational performance.[9]

II. POSSIBLE REFERRAL CHARACTERISTICS

From the definition cited above, it would appear that an obvious consistency exists in the identification and programming of mentally handicapped individuals. After all, the definition addresses two major characteristics, subaverage general intellectual ability and deficits in adaptive behavior. It would appear that mentally retarded individuals have approximately the same developmental pattern and basically the same needs. However, as one becomes involved in working with these individuals it becomes apparent that their behavioral characteristics are extremely diverse and cover a wide range of performance.

A. Intellectual:

- subaverage intellectual ability; performs poorly on verbal and nonverbal intelligence tests
- difficulty performing abstract processes; conceptualization, generalizability, transfer
- slowness in maturation of basic intellectual functions; memory, imagination, creativity

B. Academic:

- subaverage learning performance in reading, arithmetic, and spelling
- less able in activities requiring reading and listening comprehension, following complex directions, gaining insight into problem situations, generalizing from rules and principles
- less able in written communication than oral communication
- does not learn from incidental exposure to experience
- has short attention span
- displays deficiencies in short-term memory

C. Behavior:

- lack of social competence
- has difficulty comprehending social situations
- low tolerance for frustration
- exhibits immature social behavior
- has poor self concept
- displays fear of failure
- seeks approval; therefore, easily influenced

D. Communication:

- below average for age in language skills
- has limited vocabulary
- delayed speech and language
- displays articulation disorders
- limited written communication skills
- slow processing of questions often results in delayed responses

E. Physical:

- physical development proceeds at slower rate and continues for a longer period of time

F. Secondary Handicapping Conditions:

- displays high incidence

III. SCREENING INFORMATION

A. Required:

- hearing
- vision

B. Recommended: Either/or a combination of formal and informal data

1. Formal

Group administered tests of mental ability and/or achievement.

2. Informal

- checklists
- rating scales
- anecdotal records
- basic skills inventories
- observation
- ID and PP

IV. REQUIRED EVALUATION DATA

A. Social history:

1. Educational
2. Family (using language of the home)
3. Medical

B. Assessment:

1. Individual intelligence (one required in <u>each</u> <u>area</u>)

a. Verbal

(1) Appropriate Wechsler Scale

(a) Wechsler Preschool and Primary Scale of Intelligence (WPPSI) 4 to 6 1/2 years

(b) Wechsler Intelligence Scale for Children-Revised (WISC-R) 6 to 16 years

(c) Wechsler Adult Intelligence Scale (WAIS) 16 years and above

(d) Wechsler Adult Intelligence Scale - Revised (WAIS-R)

(2) McCarthy Scales of Children's Abilities (MSCA) 2 1/2 years to 8 1/2 years

(3) Stanford-Binet Intelligence Scale - 2 years to adult

b. Performance

(1) Appropriate Wechsler Scale

(a) Wechsler Preschool and Primary Scale of Intelligence (WPPSI) 4 to 6 1/2 years

(b) Wechsler Intelligence Scale for Children-Revised (WISC-R) 6 to 16 years

(c) Wechsler Adult Intelligence Scale (WAIS) 16 years and above

(d) Wechsler Adult Intelligence Scale - Revised (WAIS-R)

(2) Columbia Mental Maturity Scale - 3 years 6 months to 9 years 11 months

(3) McCarthy Scales of Children's Abilities 2 1/2 years to 8 1/2 years

2. Adaptive Behavior (one required)

- AAMD Adaptive Behavior Scale, Public School Version - 5 to 11 years
- Adaptive Behavior Inventory for Children (ABIC)
- Alpern-Boll Developmental Profile
- Cain Levine Competency Scale (TMR) 5 years to 13 years 11 months
- Social and Prevocational Information Battery (SPIB) (Mildly Handicapped) Grades 6 through 12
- Social and Prevocational Information Battery Form T (SPIB-T) (Moderately Handicapped) Grades 6 through 12
- Vineland Social Maturity Scale - ages 0 to 30 years

3. Individual Achievement (one required)

a. Peabody Individual Achievement Test (PIAT) Grades K through 12

b. Stanford Achievement Test (individually administered) Grades 1.5 to 9.5

c. Stanford Test of Academic Skills (individually administered) - Grades 9 through 12

d. Wide Range Achievement Test (WRAT) - Grades K through 12

e. Woodcock-Johnson Psychoeducational Battery, Book 2 - Ages 3 to 80+

4. Language (one required)

- See Speech Impaired Language Section for listing of instruments.

5. Programming (required)

The programming assessment is designed to assist in developing the IEP. Each curricular area in the IEP should be evaluated with an appropriate measure.

a. Assessment of Basic Competencies

b. Brigance Inventories

(1) Brigance Diagnostic Inventory of Early Development

(2) Brigance Inventory of Basic Skills

(3) Brigance Inventory of Essential Skills

c. Bruininks-Oseretsky Test of Motor Proficiency

d. Cratty Evaluation of Children's Movement Abilities

e. Diagnostic Reading Test

f. Diagnostic Tests and Self-Helps in Arithmetic

g. Durrell Analysis of Reading Difficulty

h. Gray Oral Reading Test

i. Key Math Diagnostic Arithmetic Test

j. Motor Free Visual Perception Test

k. Purdue Perceptual Motor Survey

l. Reading Free Vocational Interest Inventory

m. Southern California Sensory Integration Tests

n. Wide Range Employment Sample Test

o. Woodcock Reading Mastery Test

V. EVALUATION DATA ANALYSIS

Primary indicators of mental retardation are behaviors such as low intellectual functioning, slow maturation, and/or an adaptive behavior difficulty; consequently, a comprehensive appraisal leading to eligibility for mental retardation should include individually administered test(s), tapping factors from verbal scales, performance scales and adaptive behavior scales. Degree of involvement is directly related to evidence of these indicators. For example, a child who is mildly mentally retarded will probably not display evidence of low intellectual funtioning until enrolled in school. Once in school, the student will not be able to perform at the rate of like-age peers. In the academic areas the student will experience difficulty in learning abstract concepts. The student will be slower in developing concepts and will require that tasks be presented in a variety of ways. Progress in learning will remain slower and the student will lag behind other students. However, the student can learn the essential skills needed for independent living and successful employment in the community.

As the degree of retardation becomes more involved, it is more easily detected. Intellectual ability and adaptive behavior remain the major aspects of consideration. Many of these individuals (depending upon the degree of retardation) may be identified before they even start to school.

VI. PROGRAMMING CONSIDERATIONS

Applying Learning Principles -

Mentally retarded students need a program of systematic instruction based upon sound learning principles and techniques which facilitate learning. Haring presents the following principles of learning:

1. Emphasize concrete, meaningful content in initial instructional presentations.
2. Insure mastery of new material through overlearning and repetition.
3. Provide the learner with methods of verbal mediation, which are extremely beneficial for learning and recalling associations between pairs and items.
4. Increase attention initially by highlighting relevant dimensions and by minimizing unnecessary stimuli.
5. Promote an atmosphere of success on which to base future learning tasks.
6. Incorporate incentives into all learning arrangements.
7. Teach sequenced information from the easy to the difficult.
8. Use a variety of methods to present material as well as to reinforce its acquisition.[10]

Focus of Programs -

In order to properly address programming considerations, it is necessary to consider the degree of retardation. This does not mean a program is designed to meet the degree of retardation, rather, that a program is designed in accordance with the student's ability to learn to function in adult life. The focus of the programs for mildly handicapped students is on developing:

1. basic academic skills
2. social competency
3. personal adjustment
4. occupational adequacy

The primary objective of the educational program is to assist the mildly handicapped individual in becoming a well-adjusted and employable adult. This means the teaching of basic survival skills and skills which enhance personal and social development.

Programs for the moderately handicapped and the severely handicapped emphasize:

1. language development
2. self-help skills
3. socialization
4. motor development

The instructional program is planned to focus on the development of practical skills. These students will need training in self-help skills such as learning to dress and care for their bodily needs.

Language development facilitates the student's ability to communicate with others. Development of appropriate and functional social skills is important as the students will need to know how to work and play with others and how to function in a social situation.

The goal of the instructional program for both levels is primarily the same, i.e., the development of maximum independence as an adult. To ensure this goal, retarded individuals, regardless of degree of mental retardation, need to acquire skills which relate to successful employment. Pre-vocational and vocational training are essential components of the instructional program if these individuals are to acquire the skills necessary for successful employment. Skills such as dependability, promptness, courtesy, willingness to accept and follow directions, and productivity are constantly emphasized to prepare the individual for employment.

A. Academics:

As stated before, the basic goal of the academic program is to prepare the retarded individual to become a well-adjusted and employable adult. Educators need to have this goal constantly in mind when developing the instructional program. The school subjects are only one aspect of the program and the objective is to keep the content of the school subjects geared to meeting the ultimate goal of the instructional program for each individual student.

1. Reading

In reading basic emphasis is placed on developing a survival vocabulary so the individual can recognize signs and labels. For the individual capable of achieving a higher level, reading instruction is provided. Programmed readers which provide immediate feedback are appropriate for retarded learners. High interest, easy-to-read books keeps the student interested in reading. The primary purpose of learning to read is to assist the retarded individual in being able to function in an adult world and for recreation.

2. Arithmetic

Basic skills in understanding number facts and their uses, skills in measurement, telling time, managing money, etc. are the concepts of concern in arithmetic. All concepts taught should be of practical use in daily living. Computational skills taught should lead to a practical application in concepts for daily living.

3. Language arts

The basic skills of writing, speaking, and listening are emphasized.

4. Social studies

Emphasis is placed on citizenship, recognition of community resources, utilization of community resources, being able to use a newspaper, and being aware of the everyday world.

5. Science

Skills taught in this area include the enviornment, nutrition, hygiene, weather conditions, etc.

B. Social:

The emphasis is toward assisting the retarded student in acquiring the ability to cope with persistent life situations and to interact effectively with others in a variety of situations. Social skills should be taught as a component of other acitivities through participation, interaction, use of appropriate social behavior for the situation, etc.

A low self-concept may be characteristic of retarded individuals. Self-concept is enhanced when a student has developed a sense of confidence and security. Experiences and exposure throughout the entire school setting should facilitate a feeling of self- confidence. Retarded students need to learn ways in which they can develop a basis for self-appraisal which leads to feelings of success.

C. Communicative Abilities:

The principal goal of the language program is the development of communication skills which contribute to independence. The focus is placed on the development of a useable and effective means of communicating. This involves developing receptive and expressive skills needed in everyday performance. Skills which are emphasized include listening, understanding concepts, appropriate responses, maintaining eye contact, etc.

D. Physical:

The physical education program for the retarded individual should concentrate on body movements and body mechanics which improve the scope of activities in which the individual can participate.

Both gross and fine motor coordination are a part of the training program. Generally, emphasis is placed on experiences which facilitate the development of perceptual motor ability. Another goal of the physical education program is that of developing a physically fit body.

I. DEFINITION

"Multihandicapped" means concomitant impairments (such as mentally retarded-blind, mentally retarded-orthopedically impaired, etc.), the combination of which causes such severe educational problems that cannot be accommodated in special education programs solely for one of the impairments. The term does not include deaf-blind children.[11]

II. POSSIBLE REFERRAL CHARACTERISTICS

For an individual to be classified as multihandicapped he/she must possess two or more handicapping conditions. Referral should be based upon the observation of a combination of the characteristics outlined in the various handicapping conditions. For example, a student who is physically handicapped may have related problems in vision, hearing, speech, other health impairments such as seizures, etc. Reference should be made to the referral characteristics cited under each handicapping condition in the document, if a student is suspected of possessing a combination of handicapping conditions.

III. SCREENING INFORMATION

A. Required:

- communication (mode of)
- hearing
- vision

B. Recommended: Either/or a combination of formal and informal data

1. Formal
   - California Test of Mental Ability
   - Goodenough-Harris Draw-A-Man Test
   - Minnesota Preschool Scale
   - Peabody Picture Vocabulary Test
   - Slosson Intelligence Test
   - Yellow Brick Road
2. Informal
   - checklists
   - rating scales
   - anecdotal records
   - basic skills inventories
   - sociometric techniques
   - observation

IV. REQUIRED EVALUATION DATA

A. Social History:

1. Educational
2. Family (using language of the home)
3. Medical

B. Assessment:*

A systematic in-depth assessment of the child shall be administered in terms of medical (including neurological, when indicated), psychological, and educational needs by a multi-disciplinary team. When a student's handicapping condition(s) is so complex that the administering of formal diagnostic measurements is considered inappropriate and/or invalid by the evaluation team, an individual educational plan will be written for the student by the multi- disciplinary team and will be based upon informal assessment and direct observation of the student by the team. When complete assessments can be administered, the requirements for each suspected handicap will be followed.

1. Individual intelligence (one required)*
   - Hiskey-Nebraska Test of Learning Aptitude
   - Leiter International Performance Scale
   - Stanford-Binet Intelligence Scale (2 years to adult)
   - appropriate Wechsler Scale
   a. Wechsler Preschool and Primary Scale of Intelligence (WPSI) (4 to 6 1/2 years)
   b. Wechsler Intelligence Scale for Children-Revised (WISC-R) (6 to 16 years)
   c. Wechsler Adult Intelligence Scale (WAIS) (16 years and above)
   d. Wechsler Adult Intelligence Scale-Revised (WAIS-R)
2. Individual achievement test (one required)*
   - Peabody Individual Achievement Test (PIAT) (Grades K through 12)
   - Wide Range Achievement Test (WRAT) (Grades K through 12)
3. Adaptive behavior (one or more required)*
   - AAMD Adaptive Behavior Scale
   - Alpern-Boll Development Profile
   - Behavior Problem Checklist
   - Cain-Levine Social Competency Scale
   - Denver Developmental Screening Test
   - Pupil Rating Scale
   - Vineland Social Maturity Scale

*Pretest Considerations - Body positioning with the severely/profoundly handicapped prior to commencement of any assessment is critical. Individuals with motoric involvement may have involuntary movements and will require appropriate positioning to optimize their ability to attend to tasks.

4. Communicative Abilities assessment (one required)*

   - See suggestions in "Speech Impaired" Section

5. Other*

   a. learning processes (one to assess the deficit area)

      (1) visual perception

         - Bender Visual-Motor Gestalt Test (Koppitz scoring)
         - Developmental Test of Visual-Motor Integration
         - Frostig Developmental Test of Visual Perception
         - Illinois Test of Psycholinguistic Abilities
         - Motor-Free Test of Visual Perception
         - Southern California Sensory Integration Tests

      (2) auditory perception

         - See suggestions in "Speech Impaired" Section

      (3) motor development

         - Lincoln-Oseresky Motor Development Scale
         - Oseretsky Tests of Motor Proficiency
         - Purdue Perceptual Motor Survey
         - Southern California Sensory Integration Tests

*NOTE: These evaluation tools are frequently used with multihandicapped children. However, if this multiply impaired student is young (under five years) and/or appears to be of a lower functioning level, review of the Required Evaluation Data section in the Program Standards for Severely/Profoundly Handicapped is recommended.

V. EVALUATION DATA ANALYSIS

Because of the tremendous number of combinations of handicapping conditions in this category, it is essential that data gathered from the evaluation be carefully analyzed. Careful analysis is needed for eligibility, but is of even more importance in regard to program planning considerations. For example, a child who is visually impaired may learn by using materials produced in braille. However, consider a child who has both cerebral palsy and a visual impairment. Being able to read the braille may be impossible because of the gross uncoordinated movement of their hands.

As stated earlier, formal assessment may not be feasible because of the complexity of the handicap. In this case, programming considerations would have to be based upon informal assessment and observation. Initial observation to determine program needs and continuous observation to determine modifications in the program would be essential.

VI. PROGRAMMING CONSIDERATIONS

Although an individual program that is tailored to the unique needs of the learner is a necessity for every handicapped learner, this is even more true for the multihandicapped individual. In this section, general considerations for meeting these special needs are mentioned. In addition, persons responsible for program planning will want to consult the Programming Considerations section in the other handicapping categories. Bigge and Siruis suggest the following considerations when working with the multihandicapped child.

Communication

1. Assume - until evidence proves otherwise - that students with unintelligible speech understand at a higher level than they can express, and treat and teach them accordingly.
2. Invite students who cannot talk to show you how they answer yes, no, and I don't know.
3. Invite students to demonstrate for you all the ways they know for letting people know what they want to say.
4. Teach the most vital communication skills to students for whom learning communication skills is extremely difficult. Two important skills are using gesters to express a need to be taken to the bathroom, and smiling and saying "hi" as a greeting.
5. Invite students who talk to you but cannot be understood because of unintelligible speech to:

   "Please repeat that again."
   "Please say that in another way."
   "Show me by gestures or pointing."
   "Write, type, or point to the alphabet letters or words."
6. Repeat to students what you think they tried to communicate in order to clarify. "Is that exactly correct?"
7. Find ways for students who cannot speak or write intelligibly to demonstrate increasingly difficult thinking skills. For instance, a student might classify and reclassify objects, pictures, or words mounted on blocks of cardboard by pushing them into groups.
8. Directly or indirectly encourage students to improve their speech as they study phonics, spelling, reading, and dramatic play.
9. Give students time to respond.
10. Find ways individuals who cannot talk can contribute to class discussions.
11. Ask parents or speech and language specialists how to help students improve their speech and expressive language skills.

Learning

1. If children understand, ask them what kind of adaptations special equipment, or teaching procedures work best for them.
2. Ask parents, therapists, or special education specialists what, if any, special devices or procedures are needed to help children; for example, secure papers to desks with masking tape to keep them from slipping.
3. Ask parents, therapists, or the child what safety restrictions or cautions are necessary. Help the disabled students increase their responsibility for their own health safety.

4. Unless otherwise recommended, give students the opportunity to do what their peers do even though they might walk awkwardly, fall often, or seem uncoordinated.

5. Realize that illegible writing and slowness in written or oral answers may not indicate that the students do not know their lessons.

6. Find ways for disabled students to evaluate their performances objectively so they will not be unrealistic about what they can learn and do.

7. Include all students in group learning experiences even if you have to phrase some questions so disabled students can give yes or no answers or assist them physically.

Mobility

1. Ask disabled students, their parents, or therapists to demonstrate all the ways that the students can move from place to place.

2. Ask disabled students, their parents, or therapists when and how students should be physically assisted.

3. Have volunteers assist with physical management so whenever possible disabled students can go on field trips, participate in special projects.

4. Arrange for elimination or reduction of architectural barriers.

Self-help

1. Encourage students to complete as much of every self-help task as possible.

2. Find what steps or tasks students cannot do and see if those parts can be taught with or without adaption of material, equipment, or procedures.

3. Openly discuss any uncertainties as to when or how to aid a disabled student. You should say, "I'm not sure if you would like my help. Would you?"

Attitudes

1. Ask doctors or parents about a child's understanding of his own illness and disabilities. Find out how they want teachers to respond to questions by the child and his peers.

2. Help nondisabled students and adults understand that such characteristics as drooling, unusual ways of talking, and physical awkwardness cannot be helped and are not to be ridiculed.

3. Prepare yourself and class for helping students with special needs. For example, provide a rest period for students who tire easily, remove furniture from students who are having seizures, arrange for a nondisabled child to make carbon copies of class notes for a classmate who cannot write.

4. Treat ill or disabled students as normally as possible; do not give them better grades than deserved.

5. Prepare classmates for students' return after long absences because of illness or accident (a student might be bald or wear a wig, because of cancer treatment; someone might have a missing arm or leg, or a body cast).

6. When organic deterioration affects learning, consider keeping the student with her peers even though she cannot continue to keep up in academic or physical activity.

7. Support the possible decision of children with potentially terminal diseases to cut the amount of school work and physical activities undertaken because of frequent absences, limited energy, or personal attitudes.

Resources

1. Ask the parents, school administrators, or special educators to suggest resources if and when additional help or ideas are needed. Whenever possible use disabled persons themselves as resources for ideas on how they can be helped.

2. Find ways disabled students can become resources for nondisabled persons.

3. Train and use volunteers to aid student learning and increase the independence of students who need extra help.

4. Use peers as teachers and helpers of their handicapped classmates.

5. Read articles and books on education of individuals with physical handicaps.[12]

ORTHOPEDICALLY IMPAIRED

I. DEFINITION

"Orthopedically impaired" means a severe orthopedic impairment which adversely affects a child's educational performance. The term includes impairments caused by congenital anomaly (e.g., clubfoot, absense of some member, etc.), impairments caused by disease (e.g., poliomelitis, bone tuberculosis, etc.), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns which cause contractures).[13]

II. POSSIBLE REFERRAL CHARACTERISTICS

The referral characteristics for the orthopedically impaired student fall more into the area of physical characteristics. These may include paralysis, unsteady gait, poor muscle control, loss of limb, etc. Many times the impairment is so great as to impede the expressive language of the student. It is important to note that simply because a child is in a wheelchair he may not need to be referred for consideration of special education and related services.

At this point it is necessary to approach the eligibility in a two pronged manner.

1. Once the orthopedic handicap has been established all barriers to the child's functioning must be the first item eliminated. Many times the educational deficit will not exist once the barriers to school participation have been eliminated.
2. There are some orthopedically impaired students who will continue to exhibit an educational deficit after the removal of barriers to the school program. The educational deficit may include such things as, impaired or lack of two-way communication, an academic deficit as a result of the orthopedic impairment and not as a result of the presence of barriers, and perceptual and motor deficits that attribute to the academic and/or communication deficit as a result of the orthopedic impairment.

In eliminating the barriers to the child's participation in the regular class, items such as the following should be considered: physical access to the classroom, page turners, book holders, standing boards/desks, large desks to accommodate book holders, etc.

III. SCREENING INFORMATION

A. Required:

- hearing
- vision

B. Recommended: Either/or a combination of formal and informal data

1. Formal
   - not applicable to orthopedically impaired
2. Informal
   - observation
   - checklists

IV. REQUIRED EVALUATION DATA

A. Social History:

1. Educational

2. Family (using language of the home)

3. Medical

B. Assessment:

1. Individual intelligence (one required - appropriate section when possible)

- Stanford-Binet Intelligence Scale (2 years to adult)

- appropriate Wechsler Scale

  - Wechsler Preschool and Primary Scale of Intelligence (WPPSI) (4 to 6 1/2 years)

  - Wechsler Intelligence Scale for Children-Revised (WISC-R) (6 to 16 years)

  - Wechsler Adult Intelligence Scale (WAIS) (16 years and above)

  - Wechsler Adult Intelligence Scale-Revised (WAIS-R)

2. Individual achievement test (one required)

- Peabody Individual Achievement Test

- Wide Range Achievement Test

3. Adaptive behavior (one required)

- AAMD Adaptive Behavior Scale

- Alpern-Boll Development Profile

- Behavior Problem Checklist

- Cain-Levine Social Competency Scale

- Denver Developmental Screening Test

- Pupil Rating Scale

- Vineland Social Maturity Scale

4. Communicative Abilities assessment (one required - when possible)

- See suggestions in "Speech Impaired" Section

5. Other

a. learning processes (one to assess the deficit area)

(1) visual perception

- Bender Visual-Motor Gestalt Test (Koppitz scoring)

- Developmental Test of Visual-Motor Integration

- Frostig Developmental Test of Visual Perception

- Illinois Test of Psycholinguistic Abilities

- Motor-Free Test of Visual Perception

- Southern California Sensory Integration Tests

(2) auditory perception

- See suggestions in "Speech Impaired" Section

(3) motor development

- Lincoln-Oseretsky Motor Development Scale
- Oseretsky Tests of Motor Proficiency
- Purdue Perceptual Motor Survey

V. EVALUATION DATA ANALYSIS

Prior to analyzing the data gathered on a student that is referred as an orthopedically handicapped student, there is need to discuss the eligibility of these students. To be eligible for special education and related services as an orthopedically impaired student the following must exist:

1. written statement from a physician establishing the type of orthopedic impairment,
2. the establishment of an educational deficit which is a direct result of the orthopedic impairment and is not a result of architectural barriers,
3. the need for special education and related services.

Specific parts of the evaluation data should be considered for:

1. Intellectual - to establish the student's potential and to assist in determining if a secondary handicap exists.
2. Academic - to establish the educational deficit and to assist in program development.
3. Adaptive behavior - to determine the level of independent functioning, personal responsibility and social responsibility.
4. Communicative Abilities - to determine the levels of expressive and receptive language and to assist in programming as a result of these levels, i.e., if expressive language is so affected as to make two-way communication by verbal means nil, then an appropriate type of expressive language must be established, taught, and utilized.
5. Other data - this category includes motor development assessment, perceptual assessment and vocational assessment. These assessments may yield information relative to the need for support services such as occupational therapy, physical therapy, etc. These assessments are to be used in program planning.

VI. PROGRAMMING CONSIDERATIONS

Programming considerations under multihandicapped, speech impaired, specific learning disability and mental retardation should be reviewed in determining the programming needs of the orthopedically impaired. At all times the physical education program must be adapted to meet the needs of the orthopedically impaired student.

I. DEFINITION

"Other health impaired" means (i) having an autistic* condition which is manifested by severe communication and other developmental and educational problems, or (ii) having limited strength, vitality or alertness, due to chronic or acute health problems such as heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes, which adversely affects a child's educational performance.[14]

* A change in the definition of "handicapped children" under Part B of the Education of the Handicapped Act was issued in a regulation published in the January 16, 1981, Federal Register. The reference to "autistic" children was deleted from the disability category "seriously emotionally disturbed" under the definition of "handicapped children" and added under the disability category of "other health impaired". For each area under "other health impaired," subsections will be added which specifically address autism.

IA. DEFINITION (for purposes of determination of eligibility of Autism)

Autism means a behaviorally defined syndrome which typically appears during the first three (3) years of life, and is characterized by delay/disturbances in developmental rates and sequences, responses to sensory stimuli, communicative abilities, cognitive capacities, and the ability to relate to people, events and objects.

II. POSSIBLE REFERRAL CHARACTERISTICS

Referral characteristics for the "other health impaired" student do not fall into specific intellectual, academic, behavioral, language or physical categories. Indicators of an "other" health impairment may or may not be observable. The other health impairment may adversely affect a child's educational performance. The adverse effect may be attributed to: (1) a long period of absence due to the other health impairment, (2) an inability to attend to the task for the same length of time as his/her peers due to the other health impairment and/or as a result of medication being taken for the other health impairment, (3) an inability to attend school for more than a few hours per day due to limited strength or vitality.

The "other health impaired" student may be brought to the attention of school personnel by teacher, parent, school nurse, counselor, or other persons with knowledge of the student's condition.

IIA. Possible Referral Characteristics (Autism)

An accurate diagnosis of autism may be difficult because the characteristics of this disorder may resemble those of mental retardation, communicative, hearing and/or visual disorders, and may exist concurrently with other disorders. Autistic individuals exhibit one or more of the following characteristics over a long period of time and to a marked degree, which adversely affect educational performance:

1. Developmental Rates and Sequences

   a. gross motor milestones normal but fine motor milestones are delayed

b. delay in speech

c. regressions in motor skills, e.g. stops walking, talking

d. delay in social adaptive and cognitive milestones

2. Sensory Behaviors

a. Visual

i. close scrutiny of visual details

ii. non-use of eye contact

iii. prolonged staring

iv. flicking hand in front of eyes

v. over/under response to visual cues

vi. ritualistic arrangement of objects

b. Auditory

i. close attention to self-induced sounds

ii. non-response to varying sound levels

iii. over-response to varying sound

iv. seems not to hear

c. Tactile

i. hypo/hyper response to touch and temperature

ii. prolonged rubbing of surfaces

iii. sensitivity to food textures and bizarre food preferences

iv. no response to painful stimuli

v. self-injurious behaviors

d. Olfactory

i. smells objects/repetitive sniffing

ii. licking inedibles

e. Vertibular

i. over/under response to gravity stimuli

ii. whirling without dizziness

iii. preoccupation with spinning objects

3. Communicative Behaviors

a. mutism

b. echolalia

c. inappropriate timing and content

d. flat affect; atonal, arrhythmic speech

e. no speech initiation

f. lack of conversational speech

g. hyperactive speech

h. immature speech and syntax

i. absence of gestures

j. non-communicative speech

k. delayed onset

l. perseverative speech

m. pronoun reversal

4. Social Behaviors

a. absence of social smile

b. withdrawn from people

c. avoids eye contact

d. does not attend to social stimuli

e. does not imitate other children at play

f. often frightened or anxious

g. inappropriate attachment to objects

III. SCREENING INFORMATION

A. Required if not included in physician's records:

1. hearing

2. vision

B. Recommended: Either/or a combination of formal and informal data

1. Formal

(not applicable to other health impaired)

2. Informal

a. observation

b. medical history

IIIA. Screening Information (Autism)

1. Required

a. hearing

b. vision

2. Recommended

a. Formal (not applicable)

b. Informal

i. anecdotal records

ii. basic skills inventories

iii. observation

iv. sociometric techniques

IV. REQUIRED EVALUATION DATA

A. Social history:

1. educational

2. family (using language of the home)

3. medical

B. Assessment:

1. Individual intelligence (one required)

- Stanford-Binet Intelligence Scale (2 years to adult)

- appropriate Wechsler Scale

a. Wechsler Preschool and Primary Scale of Intelligence (WPPSI) (ages 4-6 1/2 years)

b. Wechsler Intelligence Scale for Children - Revised (WISC-R) (ages 6-16 years)

c. Wechsler Adult Intelligence Scale (WAIS) (16 years and above)

d. Wechsler Adult Intelligence Scale - Revised (WAIS-R) (16 years and above)

2. Individual achievement test (one required)

- Peabody Individual Achievement Test (PIAT) (K through 12)

- Wide Range Achievement Test (WRAT) (K through 2)

3. Adaptive behavior (one required)

- AAMD Adaptive Behavior Scale (Public School version) (ages 5-11)

- Alpern-Boll Development Profile

- Balthazaar Scales for Adaptive Behavior for Profoundly and Severely Mentally Retarded

- Cain-Levine Social Competence Scale

- Denver Developmental Screening Test

- Vineland Social Maturity Scale (0 to 30 years)

4. Speech and Language Assessment (one required)

See "Speech Impaired" section for suggested instruments in speech and language areas.

5. Other

Suggested test for acquiring additional program data:

a. learning processes

- Developmental Test of Visual-Motor Integration

- Frostig Developmental Test of Visual Perception

- Illinois Test of Psycholinguistic Abilities

- Motor-Free Test of Visual Perception

- Purdue Perceptual Motor Survey

b. specific subject areas

(1) reading

- Botel Reading Inventory
- Diagnostic Reading Test
- Durrell Analysis of Reading Difficulty
- Gates-McKillop Reading Diagnostic Test
- Gilmore Reading Test
- Gray Oral Reading Test
- Woodcock Reading Mastery Test

(2) arithmetic

- Diagnostic Chart for Fundamental Processes in Arithmetic
- Diagnostic Tests and Self-Helps in Arithmetic
- Key Math Diagnostic Arithmetic Test
- Stanford Diagnostic Arithmetic Test

(3) spelling

- Gates-Russell Spelling Diagnostic Test
- Reading-Free Vocational Interest Inventory
- Vocational Interests and Sophistication Assessment
- Wide-Range Employment Sample Test

IVA. Required Evaluation Data (Autism)

1. Social History
   a. educational
   b. family (Using language of the home - including developmental and medical history)
2. Assessment
   a. Individual intelligence (one required)

      Because of severe language deficits characteristic of autism, caution must be exercised in test selection. The following list of suggested tests provides examples of traditional intelligence measures as well as tests requiring less sophisticated verbal abilities.

      - Authur Adaptation of Leiter International Performance Scale (3 to 18 years) (Nonverbal)
      - Columbia Mental Maturity Scale (3 to 10 years)
      - Hiskey-Nebraska Test of Learning Aptitude (3 to 18 1/2 years) (Nonverbal)
      - Appropriate Wechsler Scale
        i. Wechsler Preschool & Primary Scale of Intelligence (WPPSI) (4 to 6 1/2 years)
        ii. Wechsler Intelligence Scale for Children - Revised (WISC-R) (6 to 16 years)

iii. Wechsler Adult Intelligence Scale (WAIS) (16 years and above)

iv. Wechsler Adult Intelligence Scale - Revised (WAIS-R) (16 years and above)

b. Individual Achievement Test (one required)

- Peabody Individual Achievement Test (PIAT) (K through 12)
- Wide Range Achievement Test (WRAT) (K through 12)
- Woodcock-Johnson Psychoeducational Battery (Ages 3 to 80+)
- Stanford Individual Achievement Test (Individually administered) (Grades 1.5 to 9.5)

c. Adaptive Behavior (one required)

- AAMD Adaptive Behavior Scale (Public School Version) (5 to 11 years)
- Alpern Boll Developmental Profile
- Callier Azusa Scale (0-9 years)
- Appropriate Devereux Scale
  - i. Devereux Adolescent Behavior Rating Scale
  - ii. Devereux Child Behavior Rating Scale
  - iii. Devereux Elementary School Behavior Rating Scale
- Learning Accomplishment Profile (LAP)
- Vineland Social Maturity Scale (0 to 30 years)

d. Language Assessment (both receptive and expressive language assessments required)

- See "Speech Impaired" section for other suggested instruments
- Boehm Test of Basic Concepts (Grades K through 12)
- Illinois Test of Psycholinguistic Abilities (2 to 10 years)
- Language Sampling and Analysis Procedures
- Peabody Picture Vocabulary Test - Revised (2 1/2 to 40 years)
- Preschool Language Scale - Revised
- Structured Photographic Language Test (4 to 8 years)
- Test for Auditory Comprehension of Language (3 to 6 years)
- Utah Test of Language Development (1 to 15 years)
- Vocabulary Comprehension Scale (2 to 6 years)

e. Observation (Required)

Observation should cover personal-social behaviors, toy play, conversational speech, emotional expression, amount of time spent in idiosyncratic repetitive behavior, and eating behavior. Information can be obtained in a variety of settings including observing the child in the home environment, classroom and play situations. The observed behaviors should be viewed in terms of developmental age so that formal assessment data and observational data can be compared. Observational data must be considered part of the educational evaluation because of the impact of behavior upon skill acquisition.

f. Other assessment Data

i. Medical

1. Neurological Evaluation

ii. Motor

1. Development Scale (gross & fine)

2. Santa Clara (gross & fine)

3. Teaching Research Motor Development Scale (gross & fine)

4. Test of Motor Impairment

iii. Programming Assessment

1. Brigance Diagnostic Inventory of Early Development

2. Brigance Inventory of Basic Skills

3. Psychoeducational Profile (PEP) (1 to 12 years)

4. Autism Screening Instrument for Educational Planning (ASIEP Krug, Arich and Almond, 1978)

5. Diagnostic Checklist for Behavior Disordered Children (Form E-2, Rimland, 1965) (Birth through 5 years)

V. EVALUATION DATA ANALYSIS

Intellectual assessment of the "other health impaired" student should be utilized to establish the potential of the student and to assist in determining the presence of a secondary handicap. Academic testing is essential in determining educational deficit and the present level of functioning. It is necessary to have a good assessment of language to determine if speech, language and/or hearing have been affected by the other health impairment. An adaptive behavior rating should be utilized to determine if the other health impairment has caused an apparent delay in the development of adaptive behavior.

Written observation may be requested by the evaluation committee to assist in providing additional data to better program for the student.

To be eligible for special education and related services as an "other health impaired" student the following must be present:

1. written statement from a physician to include

   a. type of other health impairment

   b. school limitations

2. justification of the adverse affect on educational performance which is attributed to the other health impairment

3. the corresponding need for special education and related services

VA. Evaluation Data Analysis (Autism)

The determination of autism is made difficult by the variety of symptoms, the rarity of the conditions, and the overlap with other cognitive and behavioral disorders. It is therefore very important to collect data from all areas specified in the evaluation section. Observational data and an account of the child's pattern of behavior from infancy to childhood may, however, provide some of the most useful data for both identification and programming.

VI. PROGRAMMING CONSIDERATIONS

In most cases the programming considerations listed under the Mentally Retarded and under the Specific Learning Disabilities categories will apply in part to these students. Please refer to those sections in this document.

In addition, many "other health impaired" students may need major modification of their school day such as rest periods, shortened school day, etc.

VIA. Programming Considerations (Autism)

There is no known cure for autism. The more promising treatment involves an intensive educational program designed to meet the child's individual needs in the areas of language, social skills, and self control. A development framework provides a means to describe and understand the characteristic uneven learning patterns manifested by autistic children. Various functions operate on different developmental levels within the same child. The most relevant teaching techniques should be carefully selected to correspond to the particular developmental level. For example, if a five-year old autistic child has the motor coordination of a normal five-year old, but the language comprehension of a two-year old, this child can be taught to ride a tricycle by using simple speech appropriate to his language level.

In the most severe form of the syndrome, extreme forms of self-injurious, repetitive, highly unusual and aggressive behaviors may occur. These behaviors, usually persistent, are highly resistant to change and often require unique management, treatment, or teaching strategies. Also counseling families regarding total living planning is often desirable.

Autism usually develops within the first three years of life and is a severely incapacitating condition. Since symptoms may change, even disappear, periodic reevaluations are necessary to monitor the course of the syndrome.

SERIOUSLY EMOTIONALLY DISTURBED

I. DEFINITION

"Seriously Emotionally Disturbed" means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree which adversely affects educational performance:

(1) an inability to learn which cannot be explained by intellectual, sensory, or health factors;

(2) an inability to build or maintain satisfactory relationships with peers and teachers;

(3) inappropriate types of behavior or feelings under normal circumstances;

(4) a general pervasive mood of unhappiness or depression; or

(5) a tendency to develop physical symptoms or fears associated with personal or school problems.

II. POSSIBLE REFERRAL CHARACTERISTICS

Identification of seriously emotionally disturbed students is not a simple, clear-cut task since many variables enter into the identification process. Nearly all individuals at one time or another display behaviors similar to or the same as those displayed by individuals here referred to as seriously emotionally disturbed. The primary differences between the "seriously emotionally disturbed" individual and other individuals, however, are as follows:

- the duration of the behavior. The behavior does not occur as an isolated instance, rather is long standing.
- the intensity or magnitude of the behavior. The behavior is grossly inappropriate for the time and place in which it occurs.
- the rate of the behavior. The behavior happens with a much higher frequency than is expected to occur during a given length of time under normal circumstances.
- The multiplicity of behaviors. The number of different behaviors which deviate from the norm.

At the onset of behaviors characteristic of the "seriously emotionally disturbed" child, efforts should be made to adapt the regular class program, or use other alternatives to meet the individual student's educational needs. Examples are review of difficulty of tasks, physical arrangement of classrooms, peer groups, counseling services available, teaching styles of a particular teacher, special interest classes available, etc.

Program modifications should be developed by the teacher or teachers and administrative personnel with the assistance of consultants, psychologists, counselors, or other supportive personnel. These efforts and a systematic record of the student's behavior during this period of time will aid the evaluation committee to determine whether there is a need for special education services. Documentation of attempts to deal with the child's behavior will also prove useful in developing an appropriate IEP for the student if he is determined eligible for services as "seriously emotionally disturbed."

In the case of transfer students or new students to the school, or in cases where the student displays extreme loss of behavioral controls, a highly structured special education classroom may be the most appropriate environment and immediate referral may be necessary. Examples of such extreme behaviors are: excessive physical aggression towards self or others, hysteria, or inability to control bodily functions.

Any or a combination of the behaviors listed below may characterize the seriously emotionally disturbed student:

A. Intellectual:

- intellectual functioning is not as strong an indicator as other referral characteristics

B. Academic:

- failure in skill acquisition
- severe learning deficiencies as compared to the chronological age educational expectancy
- nonattending to class instruction; short attention span
- little motivation for academic learning

C. Behavior:

1. Moods

- laughs, cries, or becomes very angry without apparent cause at times when others would show different reaction
- looks depressed almost all the time without regard to circumstances (This behavior occurs most frequently with females and is often overlooked.)
- daydreams; sits with a vacant expression, doing nothing productive (This behavior occurs most frequently with females and is often overlooked.)

2. Responses

- talks inappropriately, without regard for the questions or answers of others
- shows extreme interest in morbid, obscure, or gruesome events
- is in constant motion; compulsively manipulates objects, moves about the room excessively
- talks incessantly; frequently talks without permission or interrupts conversations
- does not seem to learn from experience; behavior does not improve with usual disciplinary methods
- acts impulsively and shows poor judgment; does not consider or understand consequences of his behavior

3. Neurotic complaints

- complains of feeling uneasy or anxious most of the time without apparent cause
- complains of being afraid of something(s) that the vast majority of people do not fear
- is overly suspicious or jealous of others

4. Interpersonal relationships

- impaired ability to build or maintain satisfactory interpersonal relationships with peers and teachers

- cannot make or keep friendships
- repeatedly engages in fights or misunderstandings
- cannot work with others in learning situations
- cannot play with others cooperatively
- cannot communicate with or respond to others due to an apparent lack of awareness of the real world

5. Self-concept

- may have slovenly, unkempt appearance
- fearful of new situations, unwilling to attempt new or difficult tasks
- shows extreme negative reaction to minor failures
- unable to evaluate behavior realistically; brags or puts down own accomplishments

D. Communicative Abilities:

- does not speak or speaks only when spoken to
- speech that is unusually fast or slow
- speaks with marked dysfluency; stutters, clutters, or other-wise interrupts the flow of speech
- voice unusually high, low, loud, soft, or scratchy
- uses primarily jargon, profanity, or other speech inappropriate to context

E. Physical

- complains of physical pain, sensations or discomfort or impairment of function of the body without organic basis
- engages in repetitive, stereotyped motor behavior, such as tics, nailbiting, or rocking
- habitually sucks thumb, fingers
- overcome frequently by drowsiness or sleep during the day, seems tired or without energy

III. SCREENING INFORMATION

A. REQUIRED:

- hearing
- vision

B. RECOMMENDED: Either/or a combination of formal and informal data

1. Formal

- Burks' Behavior Rating Scale
- Conner's Parent Rating Scale (Parent)
- Conner's Teacher Rating Scale (Teacher)
- appropriate Devereux Scale

a. Devereux Adolescent Behavior Rating Scale

b. Devereux Child Behavior Rating Scale

c. Devereux Elementary School Behavior Rating Scale

- Kohn's Symptom Checklist (Teacher)
- Louisville Behavior Checklist (Parent)
- Patterson's Problem Checklist (Teacher)
- Peterson-Quay Rating Scale
- Preschool Behavior Questionaire (Teacher)
- Walker Problem Behavior Identification Checklist

2. Informal
   - checklists
   - rating scales
   - anecdotal records
   - self-concept inventories
   - sociometric techniques
   - classroom work samples

IV. REQUIRED EVALUATION DATA

A. Social History
   1. Educational
   2. Family (using language of the home)
   3. Medical

B. Assessment:
   1. Individual intelligence (one required)
      - Columbia Mental Maturity, 3rd ed. (3-9)
      - Leiter International Performance Scale (2-18)
      - Stanford-Binet (Rev. Form LM) (2 - adult)
      - appropriate Wechsler Scale
        a. Wechsler Preschool and Primary Scale of Intelligence (WPSI) (ages 3 - 6)
        b. Wechsler Intelligence Scale for Children Revised (WISC-R) (Grades 1 - 12)
        c. Wechsler Adult Intelligence Scale (WAIS)
   2. Individual achievement test (one required)
      - Peabody Individual Achievement Test (PIAT) (K-12)
      - Wide Range Achievement Test (WRAT) (K-12)
      - Woodcock-Johnson Psychoeducational Battery, Book 2
   3. Adaptive behavior (one required)
      - Adaptive Behavior Inventory for Children (SOMPA) (5-11)
      - Adaptive Behavior Scale - AAMD (3-12 and up)
      - Vineland Social Maturity (0-adult)

4. Language assessment (one required both in the areas of receptive and expressive language as listed in the section on Speech Impaired)

5. Other

   a. perceptual-motor (one required)

      - Bender Visual-Motor Gestalt Test (Koppitz scoring)

      - Human Figures Drawing Test (Harris scoring)

   b. behavioral observation (required)

      - The observation step is especially important when identifying pupils with behavioral handicaps. Teachers who are responsible for some 30 pupils can hardly be expected to give their full attention to one pupil for more than a short period of time. An objective observer, who can concentrate on one pupil and his reaction to his environment, may be able to note particular aspects of the environment that set off certain behaviors. If possible, the observer should see the child in a variety of settings, i.e., classroom (with different teachers if in a secondary school), playground, etc.

        Attention should be given to noting specific behaviors and their FREQUENCY, DURATION and INTENSITY. Other variables which should be considered in making an observation are the setting in which the behavior occurs, the stimulus for the behavior, the sequence of behavior, the time the behavior occurs, and the results of the behavior on the pupil and others.

        In making observations it is important to remember that only behaviors can be observed. The processes and characteristics which caused the behaviors cannot be observed but inferences about the presence or absence of these characteristics and processes can be made based on behavioral evidence. By definition, this behavioral evidence is observable and other may look at it to verify the existence of the behaviors or to make decisions about their agreement with the inferences that have been made based on the evidence.

        The basic methods for recording observations are anecdotal records, participation charts, checklists, rating scales, and behavior counting and charting and coding procedures. The decision about which type(s) of records to use at any given time must be made on the basis of the instructional decision which is to be made using the observation data, i.e., for structured situations, a checklist might be most appropriate, but for situations in which behavior may occur spontaneously and unpredictably, another method would be more appropriate.[15]

   c. learning processes (optional)

      - Illinois Test of Psycholinguistic Abilities

      - Purdue Perceptual-Motor Survey

      - Southern California Sensory Integration Tests

      - Woodcock-Johnson-Swassing-Burke Checklist of Observable Modality Strength Characteristics (K-7)

   d. specific subject areas (one required from deficit area(s) as determined by intellectual, general achievement, and educational performance)

      (1) General

         - Brigance Inventories of Basic Skills

      (2) reading

         - Durrell Analysis of Reading Difficulty (1-6)

         - Spache's Diagnostic Reading Scales (K-7)

         - Woodcock Reading Mastery Test (1-12)

      (3) arithmetic

         - Key Math Diagnostic Arithmetic Test (K-7)

(4) spelling

- Gates-Russell Spelling Diagnostic Test
- Lincoln Diagnostic Spelling Test
- Spellmaster: Spelling, Testing, and Evaluation

e. vocational

- General Aptitude Test Battery
- Reading-Free Vocational Interest Inventory
- Vocational Interests and Sophistication
- Wide-Range Employment Sample Test

V. EVALUATION DATA ANALYSIS

The purpose of an analysis of the evaluation data is to determine if the behaviors exhibited by the child are of a marked degree and displayed over an extended period of time such that the child is seriously emotionally disturbed, and whether this handicapping condition has affected his/her educational performance adversely such that special education is necessary.

Many students experience behavior problems similar in nature to those of the student diagnosed as seriously emotionally disturbed; however, the degree of severity, and the duration of the behavior have not affected his/her educational performance adversely such that special education and related services are needed. Those students experiencing behavior problems but not to the degree that the student has a need for special education and related services should be referred to appropriate support agencies, e.g., psychologist, mental health center, etc. for services.

The second function of the analysis of evaluation data is to provide information regarding programming considerations. Analysis of the evaluation data provides information regarding the types of behavior the learner displays. Specific identification of behaviors assists the educator in determining an appropriate educational program.

VI. PROGRAMMING CONSIDERATIONS

There is no one correct way to program for seriously emotionally disturbed students. Most teachers have received training which is underpinned by a particular theory, i.e., psychoanalytic, humanistic, etc. Regardless of the theory, the teacher must be aware of various approaches which may be realistically and effectively used in the classroom. For the seriously emotionally disturbed student to succeed, a sound educational and social program must be provided. The attempt to increase both behavioral and academic performance is grounded in

an educational plan which provides growth through remediation of social, emotional, and academic performance. To accomplish this, individualized and sequential programming techniques must be utilized.

It is recommended that, whenever possible, regularly scheduled programming conferences be held involving the school personnel serving the severely behavior disordered student and a psychologist, psychiatrist, or supervised psychological examiner who has worked with the student(s). This related service can provide the needed support to school personnel in developing a comprehensive program for the student.

Knowledge and an understanding of behavioral principles as they apply to the management of students are essential to the teacher of seriously emotionally disturbed students. The following list of basic techniques are applicable to any class setting in which seriously emotionally disturbed students are being served.

TECHNIQUES FOR MANAGING MISBEHAVIOR

1. Stop misbehavior in time.
2. Program for a variety of changes.
3. Make tasks clear and orderly and give the child time to complete one task before beginning another.
4. Comment positively when the student is attending appropriately to a task.
5. Establish limits and maintain consistent, clear ground rules.
6. Manage transitional times with quieting down periods between two activities.
7. Set up filler corners, activity centers a child can go to when he has completed required activities.
8. Set up a quiet corner where a child can go to be alone, to cry, or to calm down.
9. Provide success; be sure the material is relevant, interesting, and appropriate for the child.[16]

In addition to the techniques listed above, other procedures which might be included in programming are:

- contracts - academic, behavior
- time-out areas, or time-out seclusion rooms
- contingency reinforcement programs

The relationship between the teacher and student is of utmost importance. The teacher is responsible for establishing a student-teacher relationship for the purpose of enhancing academic and social growth in the children for whom they are responsible. This relationship is built upon mutual trust, concern, and being supportive of the student's efforts. It is a relationship which is built over a period of time -- time in which the student receives

support, encouragement, and corrective feedback.

In some instances it may be necessary to systematically and consistently manage behavior of a seriously emotionally disturbed student on a 24-hour basis, in order for the child to benefit from the educational program. In such cases, referral for residential placement may be necessary and appropriate.

A. Academic:

Diagnostic procedures are utilized to determine the student's current level of functioning. Students who are seriously emotionally disturbed often possess a wide discrepancy in academic skills. The basic academic skills, such as reading, writing, spelling, arithmetic, and so on, are taught while appropriate social-emotional responses are being learned. Whenever possible, children working on grade level should be maintained in the regular classroom in those subject matter classes. For the student who has difficulty attending, the teacher may want to utilize some programmed learning materials which provide immediate feedback. Learning machines or multi-media materials may also prove beneficial in working with some seriously emotionally disturbed students. In reading, high-interest, easy-to-read books may be beneficial.

B. Social:

Social and emotional skills are best learned as part of everyday interaction with teacher, peers, and other adults. The social- emotional part of the curriculum should be so interwoven with the rest of the curriculum that it is impossible to segregate it as a proportional part. There is no substitute for a well-managed environment in which naturally occurring social rewards shape and maintain appropriate behavior. Commercial instructional materials which are designed to teach students social and emotional responses have become available. These materials assist students in understanding themselves and how to get along with others. These materials include:

- The Self-Control Curriculum
- The Social Learning Curriculum
- Developing Understanding of Self and Others (DUSO)
- Toward Affective Development (TAD)

C. Language Abilities:

In order to develop an adequate language system, an individual must possess the necessary behavioral controls to attend and respond to the environment. Many seriously emotionally

disturbed individuals cannot or do not relate to individuals in the environment and the result may be serious language disturbances.

For the more extreme problems, intervention techniques must be implemented which result in the student attending to the environment. These students may also exhibit deviant vocal qualities. While some children may require the assistance of a trained language therapist, the development of language is also a responsibility of the classroom teacher.

D. Physical:

Systematic observation is essential in the delineation of physical difficulties. As these difficulties are identified, intervention techniques may be implemented. One approach to the elimination of inappropriate behaviors is the substitution of appropriate behavior. The goal of the instructional program is to provide educational intervention strategies which eliminate or establish behavior to maximize academic achievement and behavior performance. The ultimate goal is that the student can be served in the regular classroom and be maintained by support services on a needed basis.

SEVERELY/PROFOUNDLY HANDICAPPED

I. DEFINITION

[1]Severely/Profoundly handicapped means an impairment(s) which requires an instructional program focusing on the development of basic life skills[2] and frequently, requires more extensive related educational services[3] than are needed by other handicapped children.

1. These children will exhibit serious functional intellectual retardation, often possess accompanying motoric, sensory, and/or communicative impairments, and may engage in socially maladaptive behavior.

2. Basic life skills include motor, self-care, perceptual, cognitive, communication, social, domestic living, community living, recreation/leisure time, and vocational skills.

3. Needed services may include physical therapy, occupational therapy, speech-language pathology, school health services, parent counseling and training, social work, transportation, special physical education/recreation, and psychological/ other assessment services.

II. POSSIBLE REFERRAL CHARACTERISTICS

Individuals in this handicapping category represent an extremely heterogenous population. The wide inter - and intra - variations in the multiple problems and existing abilities of the severely/profoundly handicapped should always be kept in mind. Due to the diversity of this group, there is no representative behavioral or physical profile. However, there are basic descriptions of behavioral characteristics and physical conditions which are frequently observable in the severely/ profoundly handicapped individual.

Children who are severely/profoundly impaired are typically identified by personnel from the medical field. Because of severe developmental delays and/or chronic medical involvement, these children are typically referred for services at a very young age. These individuals are often difficult to assign a specific diagnosis of physical, mental, communicative, or emotional impairment. However, many possess characteristics and behaviors associated with one or more of these disabling conditions. Identifiable characteristics within this group usually fall under the categories of intellectual, physical, social/ emotional and communication deficits.

A. Intellectual

- intellectual functioning of approximately four standard deviations below the norm
- lack of ability to perform basic academic tasks

B. Physical

- frequent pronounced delays in motor development. Involvement may vary from inability to perform basic milestones such as rolling over, grasping objects, etc., to no major motor skills impairment
- tactile, visual, and/or auditory deficits are frequently present
- seizure disorder, cerebral palsy, spinal cord injury, hydrocephaly, microcephaly, congenital heart impairment and other serious medical complications may be present

C. Social

- often do not display interaction skills

- may exhibit inappropriate or bizarre behaviors

A.

Self Injurious	Self Stimulatory
hand biting	finger flicking
head banging	light fascination
scratching	hand waving
eye poking	body rocking

Inappropriate Vocalizations	Aggressive Behaviors
screaming	biting
repetitious verbalizations	hitting
	kicking

D. Communication

- profound delay in speech and language development

- receptive communication abilities are often limited to the comprehension of simple commands and phrases

III. SCREENING

A. Required

- communication (mode of)

- hearing

- vision

B. Recommended

1. Informal

- observational

1. Home environment

2. Structured environment

- interview

1. Parent

2. Past teachers

3. Medical personnel

IV. REQUIRED EVALUATION DATA

A. Social History

1. Educational

2. Family (using language of the home)

3. Medical

B. Assessment*

An in-depth multifaceted assessment of a severely handicapped child is needed to acquire appropriate information regarding the child's abilities and disabilities. Assessments in

*Pretest Considerations - Body positioning with the severely/profoundly handicapped prior to commencement of any assessment is critical. Individuals with motoric involvement may have involuntary movements and will require appropriate positioning to optimize their ability to attend to tasks.

each of the following areas constitute a multifaceted assessment for a severely/profoundly handicapped child: Individual Intelligence, Sensorimotor, Functional Skills, Motor, and Communication. Such a comprehensive assessment should be performed by a multidisciplinary team. Members of the team should be cognizant of the numerous problems inherent in valid assessment of severely/profoundly handicapped children. In view of these problems, we recommend that members of this team make appropriate modifications/adaptations in test administration and interpretation to accommodate sensory, cognitive, motor, and communication deficiencies these children exhibit. To optimize the child's performance, members of the team are encouraged to appeal to the best receptive and expressive modes by making appropriate adaptations and creative manipulations of assessment techniques and materials.

1. Individual Intelligence (one required)

   Examiners should be flexible in their approach with this population. Since most standard and frequently used instruments were not standardized (or originated) on or for a severely handicapped population, the ingenuity and creativity of the examiner to optimize use of available testing materials is necessary.

   A non-verbal child may have typewriter skill or a communication board with which to answer questions on the exam. Consider use of adaptive devices that may be used to convey answers.

   The ulitmate goal in testing is to optimize the child's response and appeal to the best expressive mode. Pretest or trial items, (often trial and error methodology), will begin to identify for the examiner how to best utilize testing materials.

   - Bayley Scale of Mental Development (0 - 30 months)
   - Callier Azusa Scale (0 - 5 years)
   - Catell Infant Scale of Intelligence (0 - 30 months)
   - Merril Palmer Tests of Mental Ability (1.5 years - 6 years)
   - McCarthy Scales of Children's Abilities (2.5 years - 8 years)
   - Ordinal Scales of Psychological Development (0 - 24 months)
   - Peabody Picture Vocabulary Test (2.5 years - 18 years)
   - Stanford Binet (2 years - adult)

2. Sensorimotor (one required)

   Instruments constructed to assess sensory integrative and subsequent motor function will often involve active, task/goal oriented behaviors between the examiner and the subject. Due to the possible multiplicity of handicapping conditions, a checklist evaluation form may be the instrument of choice.

- Bayley Infant Scales (0 - 2.5 years)
- Columbia Mental Maturity Scale (3 years - 9.10 years)
- Denver Developmental Screening Test (1 month - 6 years)
- Developmental Record (0 - adult)
- Developmental Test of Visual - Motor Integration (2 years - 8 years)

3. Functional Skills (one required)

Each of the instruments listed below assesses the student's levels of performance in several areas, including pre-academics, social, independence, responsibility, domestic living, community living and vocational.

- AAMD Adaptive Behavior Scales: Public School Version (3 years - adult)
- Brigance Diagnostic Inventory of Early Development (0 - 6 years)
- Callier Azusa (0 - 9 years)
- Camelot Behavioral Checklist (preschool - adult)
- Developmental Profile (infant - 12.5 years)
- Learning Accomplishment Profile (LAP) (0 - 6 years)
- Uniform Performance Assessment System (0 - adult)
- Vineland Scales of Social Maturity (infant - adult)

4. Motor (one required)

- Bayley Scales of Motor Development (Gross & Fine Motor)
- Milanti - Comparetti Scales of Motor Development (Gross & Fine Motor)
- Peabody Developmental Motor Scales (Gross & Fine Motor)
- Stanford Function Developmental Assessment (Gross & Fine Motor)
- Teaching Research Motor Development Scale (Gross & Fine Motor)

5. Communication (one required)

- See Speech Impaired Section for other measures available
- Environmental Language Inventory (12 months - 36 months)
- Environmental Pre-Language Battery (12 months - 18 months)
- Houston Test for Language Development

  Part 1 (6 months - 3 years)

  Part 2 (6 months - 6 years)
- Receptive - Expressive Emergent Language (REEL) (0 - 3 years)
- Sequenced Inventory of Communication Development (4 months - 18 months)
- Utah Test of Language Development and Language Sampling Supplement (1 year - 15 years)
- Verbal Language Development Scale (1 month - 16 years)

V. EVALUATION DATA ANALYSIS

Comprehensive analysis of the evaluation data is required to determine the current needs of the

severely handicapped learner. Once again, consideration must be given to the implications of test validity when administered to severely/profoundly handicapped individuals. Current ability levels need to be identified from individual evaluations and combined to form a cohesive description of the student's present skill level. This description will provide needed information concerning eligibility, specific areas of strength/weakness, and related support services needed to ensure appropriate programming. Once this data is compiled, the multidisciplinary team will review the data, determine current needs, and write long term goals to reflect these needs. The movement toward an educational/training placement must be methodical in nature, taking into consideration all aspects of behavior exhibited by the severely/profoundly handicapped individual.

VI. PROGRAMMING CONSIDERATIONS

Curriculum content relevant to the education/training of severely/ profoundly handicapped individuals is very different than the curriculum for mildly handicapped children. Instead of the basic academic components of reading, writing, and arithmetic, severely impaired children must first learn to eat, walk, communicate, use the toilet, dress, interact socially. The overall goal is to develop skills which enable the severely handicapped to be as independent as possible. Such functional skills are milestones for severely/profoundly handicapped children and are reflected in a curriculum which can be subdivided into several major areas: sensory development, motor, communication, cognition, social development, self-care, daily living, community living, recreation/ leisure time, and vocational skills.

With this population consideration must be given to the amount of one to one instruction required to maintain and increase/decrease skills and/or behaviors. A severely/profoundly handicapped individual may not exhibit independent work and/or play abilities. The lack of initiative reduces the benefit of group instruction and free play. A structured schedule including one-to-one instruction, group activity, and independent leisure time is needed to ensure all levels of independence and skills are attained.

Repetition of activities is an integral factor in the movement of the severely/profoundly handicapped individual from being dependent on others for assistance to the ability to perform tasks with some degree of independence. During the instructional day opportunities should be provided for the student to practice designated skills. Since the curriculum for the severely involved includes activities of self care and daily living, it is often difficult to provide practice and keep the activity in a natural environment. Classrooms should be designed so that areas are designated for such activities, i.e., a sink with hot and cold running water for

practicing toothbrushing and hand washing, a bed in a secluded area of the room to practice bed-making, etc. If the environment is familiar and realistic, the severely/profoundly handicapped student is able to integrate the newly introduced activities with experiences he/she has witnessed in that specific area.

In implementing an educational program, attention should be given to the instructional techniques used, the functionality of the skills taught, and the age-appropriateness of the instructional materials and activities used. Severely/profoundly handicapped children exhibit greater difficulties in learning than do their moderately and mildly handicapped peers. Nevertheless, systematic instructional techniques including behavior and task analysis, behavior shaping, imitation, chaining, prompting, fading, and generalization training have proven to be effective in producing positive behavioral changes in these children.* These techniques should be used to teach skills which are functional, i.e., will enhance the child's ability to participate in society with maximum independence. Teachers should also be guided by the principle of "age-appropriateness" in selecting instructional materials and activities as part of an educational program. Even though severely handicapped children may be performing at a considerably lower level, use equipment and tasks which are appropriate for the chronological age of the child. By concentrating on the use of systematic instructional techniques and age-appropriate materials and activities to teach functional skills in natural environments, teachers will be providing severely/profoundly handicapped children with an opportunity for optimal educational progress.

*Note: There are many references available which provide information on the above mentioned instructional techniques. The following are examples:

1. Effective Education and Behavioral Programming for Severely and Profoundly Handicapped Students, Dorthy Popovich - author.
2. The Severely and Profoundly Handicapped, Etten, Arkell, and Etten - authors.
3. Behavior Modification for the Classroom Teacher, Rosenberg - author.

Curriculum areas which should be included in developing programs for severely handicapped children are outlined below. Adjacent to each of the curriculum areas are sample skills representative of that area. The list of skills associated with each curriculum area is not intended to be all-inclusive, but rather to furnish examples of skills that might be developed in a specific area.

CURRICULUM AREA	SAMPLE SKILLS
Sensory Development	responding to visual cues following moving objects responding to auditory cues using tactile cues
Motor Skills	Gross motor: head control moving from lying to sitting position sitting standing walking running using a wheelchair climbing stairs throwing catching Fine motor: reaching grasping manipulating small objects - beads, blocks, clay, puzzle parts uses crayons/pencils uses scissors
Communication	Receptive language: responding to spoken sounds following simple commands identifying named objects/persons responding to manual signs using a communication board Expressive language: opening and closing mouth moving tongue and lips imitating sounds producing words labeling objects responding to questions using manual signs using a communication board
Social Skills	relating appropriately to others verbally and physically engaging in appropriate behavior while in individual and group situations following school and community rules taking turns cooperating with others caring for property engaging in social amenities displaying appropriate table manners engaging in appropriate sexual behavior refraining from inappropriate aggressive behaviors refraining from self-abuse refraining from excessive self-stimulation

Cognition	matching objects matching pictures identifying pictures of common objects identifying body parts identifying numerals sequencing objects, pictures labeling objects, body parts rote counting counting objects classifing objects identifying letters, words labeling letters, words
Self-Care	toileting opening and closing mouth moving tongue and lips chewing swallowing using utensils to feed self drinking liquids using a cup, glass, straw, fountain dressing/undressing washing hands and face bathing blowing nose brushing teeth handling objects in a safe manner keeping hair clean and neat caring for one's skin shaving caring for nails
Domestic Living	tidying caring for furniture cleaning floors, windows, counters storing and retrieving food opening containers preparing beverages and food using a stove serving food table setting and clearing washing and drying dishes doing laundry bed making sewing and mending using dial and touchtone telephones
Community Living	shopping handling money using public transportation eating in fast food restaurants, cafeterias, sit-down restaurants crossing streets obeying community laws relating to neighbors and strangers reading signs depositing/withdrawing from banks using pay telephones using public restrooms waiting in line engaging in appropriate public sexual behavior

Recreation/Leisure Time	engaging in solitary play, parallel play cooperative play using toys using television using radios using stereos dancing playing board games playing card games playing table games playing musical instruments making simple home-crafts playing indoor team sports engaging in solitary sports playing outdoor team sports making dates attending movies going to lounges
Vocational	beginning a task promptly staying on task completing a task dressing appropriately for work interacting appropriately works with co-workers interacting appropriately works with supervisors notifing supervisor of illness or anticipated tardiness using a time-clock telling time completing an application form seeking assistance when needed sorting materials assembling products custodial skills housekeeping skills food service skills stock handling skills basic clerical skills groundskeeping skills animal care skills agricultural skills

SPECIFIC LEARNING DISABILITY

I. DEFINITION

"Specific Learning Disability" means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not include children who have learning problems which are primarily the result of visual, hearing or motor handicaps, of mental retardation, or of environmental, cultural, or economic disadvantage.[17]

II. POSSIBLE REFERRAL CHARACTERISTICS

Students identified as having a specific learning disability are noticed by a number of characteristics. As you review the referral characteristics, it becomes evident that almost every student displays some of these characteristics. However, the learning disabled student will possess and display a "clustering" of these characteristics. That is to say, as the student with a specific learning disability is observed, several of the listed characteristics will remain fairly consistent. The more severe the specific learning disability, the more characteristics which are identifiable for that individual.

Characteristics may also appear in any combination for different students. It soon becomes very obvious that each student who has a specific learning disability is truly unique and that no typical pattern is apparent for this handicapping category.

The existence of one or more characteristics indicates that a "process deficit" may exist. Further evaluation would be required to assist the evaluation committee in distinguishing between the primary handicapping condition of specific learning disability and the slow-learning or under-achieving child.

Furthermore, a specific learning disabled child, functioning at or above grade level, should not be considered for special education services.

One or more of the following characteristics may indicate a "process deficit":

A. Intellectual:

- the child who appears to be able to function at his intellectual level but does not perform academically when exposed to conventional teaching strategies

B. Academic:

- scores indicate inconsistency and great variability between expectancy and performance
- short attention span; unable to concentrate on any one task for very long

- easily distracted by irrelevant stimuli

- disorganized in the use of books and materials

- unable to follow and understand class discussion, appears to be inattentive or daydreaming

- difficulty understanding meaning of time and fails to comprehend the requirements of completing assignments within a certain time

- difficulty applying phonetic rules and syllabication in spelling

1. Reading

   a. visual processing

      - visual discrimination difficulties and confusion of similar letters and words

      - letter and word reversals and inversions

      - difficulty in following and retaining visual sequences

      - word substitutions

      - distracted reading; skipping and jumping words

      - omission of words, phrases, and sentences

      - slow recognition of words

   b. auditory processing

      - difficulty in separating words into their component phonemes and syllables or in blending them into whole words

      - difficulty in spontaneous recall of sounds associated with letters and words

      - disturbances in auditory sequencing

      - general preference for visual activities over auditory tasks

2. Writing and Drawing

   - inability to form letters or digits correctly

   - difficulty in staying on or between lines

   - difficulty in judging length and width of letters

   - difficulty in spatial organization; difficulty in identification or matching of shapes; rotation or distortion of drawings of geometric designs

   - reversal of letters and digits

   - difficulty in discriminating left from right

3. Arithmetic

   - difficulty analyzing and solving math problems of various complexity (one or multiple step), including those involving probability

   - difficulty in associating the spoken form with the correct printed material

   - difficulty in learning the cardinal and ordinal system of counting

   - difficulty in understanding the meaning of the process sign

   - difficulty in understanding the arrangement of numbers on a page

   - inability to follow and remember the sequence of steps used in various mathematical operations

   - difficulty with concepts of space, time, size, distance, quantity and linear measurement

C. Behavior:

- hyperactivity/attentional deficit disorder, constant motion, inability to attend to a specific task for required periods of time
- emotional lability; easily upset, anxious, low frustration threshold, may exhibit rapid change from one mood to another
- impulsivity; uninhibited, acts without thinking
- distractibility; difficulty in attending to dominant stimuli; may abnormally fixate on unimportant details
- perseveration; attention becomes fixed upon a single task which is repeated over and over
- may frequently demonstrate an inability to assimilate, store or recall visual and/or auditory stimuli
- perceptual-motor impairments; inability to identify or discriminate between visual or auditory stimuli
- may be confused in his relationship to the physical environment and become disoriented in a familiar setting such as school, playground, and neighborhood
- may frequently disrupt the classroom, demand attention to an inappropriate degree, speak out of turn, or exhibit an inability to control responses
- may disregard or fail to understand the feelings of others
- may demonstrate a low tolerance for change; may react inappropriately to stimuli
- may lack self-sufficiency, seldom initiates appropriate activities, may have limited knowledge or acceptance of age role, and may compensate by acting foolish or making fun of others
- has difficulty interpreting emotions, attitudes, and intentions others communicate through nonverbal aspects of communication (facial expressions and body language)

D. Communicative Abilities:

- fails to grasp simple word meanings
- comprehends words in isolation but fails to comprehend in connected speech
- frequently uses incomplete sentences and has numerous grammatical errors as evidenced by poor use of pronouns and verb tenses
- unable to organize and express ideas even when adequate information is provided, relates minor or irrelevant details
- cannot give clear and appropriate directions
- does not recognize and understand figurative language such as similes, metaphors, idioms, personification, alliteration
- uses gestures extensively while talking or in place of speech
- cannot predict outcomes, make judgements, draw conclusions or generate alternatives after appropriate discussion
- has problems interpreting and/or using vocal pitch, intensity, and timing for purposes of communicating subtle distinctions in emotion and intention
- asks questions and/or responds to questions inappropriately (especially "wh" and "how" question forms)
- has difficulty comprehending and using liguistically complex sentences
- has problems acquiring and using grammatical rules and patterns for word and sentence formation
- has difficulty interpreting or formulating (oral or written) compound or complex sentences, sentences which compare and contrast ideas or show cause-effect relationships

- cannot write an organized paragraph using related sentences of varying length and grammatical complexity

E. Physical:

- general coordination poor; awkwardness evident in skipping, climbing, running, walking, jumping, hopping, etc.
- may fall or stumble frequently or maintain equilibrium by touching tables, chairs, or desks when moving about the room
- may exhibit difficulty with fine motor coordination tasks
- may have difficulty differentiating between right and left; may exhibit directional confusion; mirror-writing, reversals, inversions, or rotations of letters and/or numerals
- often is disorganized in personal appearance

III. SCREENING INFORMATION

A. Required:

- hearing
- vision

B. Recommended: Either/or a combination of formal and informal data

1. Formal

- Group achievement and/or mental abilities tests

IV. REQUIRED EVALUATION DATA

A. Social History

1. Educational
2. Family (using language of the home)
3. Medical

B. Assessment:

1. Individual intelligence (one required)

- appropriate Wechsler Scale

a. Wechsler Preschool and Primary Scale of Intelligence (WPPSI) (ages 4-6 1/2 years)

b. Wechsler Intelligence Scale for Children Revised (WISC-R) (ages 6-16 years)

c. Wechsler Adult Intelligence Scale (WAIS) (ages 16 years and above)

d. Wechsler Adult Intelligence Scale - Revised (WAIS-R)

2. Individual Achievement (one required)

- Peabody Individual Achievement Test (PIAT) (grades K-12)
- Stanford Achievement Test (individually administered) (grades 1.5 to 9.5)
- Stanford Test of Academic Skills (individually administered) (grades 9 to 12)
- Wide Range Achievement Test (WRAT) (grades K - 12)
- Woodcock-Johnson Psychoeducational Battery. Book 2 (ages 3 - 80+)

3. Adaptive Behavior (one required)

   a. Appropriate Devereux Scale

      (1) Devereux Adolescent Behavior Rating Scale

      (2) Devereux Child Behavior Rating Scale

      (3) Devereux Elementary School Behavior Rating Scale

   b. Appropriate Burks' Scale

      (1) Burks' Behavior Rating Scales, Preschool and Kindergarten

      (2) Burks' Behavior Rating Scales, Elementary and Secondary Form

   c. Pupil Rating Scale by Mykelbust

4. Language Abilities Assessment (one required)

   - See "Speech Impaired" Section for listing of instruments

5. Other

   a. learning processes

      (1) visual perception (one required)

         - Bender Visual-Motor Gestalt Test (Koppitz scoring)

         - Developmental Test of Visual-Motor Integration

         - Frostig Developmental Test of Visual Perception

         - Illinois Test of Psycholinguistic Abilities (ITPA) subtests: Visual Reception, Visual Association, Visual Closure, and Visual Sequential Memory

         - Motor-Free Test of Visual Perception

         - Slosson Drawing Coordination Test for Children and Adults

         - Southern California Figure-Ground Perception Test

      (2) auditory perception (one required)

         - See "Speech Impaired" Section for listing of instruments

           (as determined by committee)

      (3) motor development

         - Bruininks-Oseretsky Tests of Motor Proficiency

         - Purdue Perceptual Motor Survey

         - Southern California Sensory Integration Tests

   b. Observation

      A Systematic written observation of the student's performance in an academic setting is required. Data should include the relevant behavior, relationship of the behavior to the child's academic functioning, modifications of teaching strategies made by regular class personnel and the outcome of each modification attempted, length of observation time, day of week, and time of day observation was completed.

   c. specific subject areas (one required from deficit area(s) as determined by intellectual, general achievement, and educational performance)

      (1) listening comprehension

         - Detroit Test of Learning Aptitudes (relevant subtests)

- Illinois Test of Psycholinguistic Abilities (relevant subtests)
- Listening Comprehension subtest of any standardized individual reading measure
- Test of Auditory Comprehension of Language
- Test of Language Development
- The Token Test for Children
- The WORD Test

(2) oral expression

- Carrow Elicited Language Inventory
- Detroit Tests of Learning Aptitude (relevant subtests)
- Structured Photographic Language Test
- Systematic observation analysis of language (oral sample)

(3) basic reading and reading comprehension

- Botel Reading Inventory
- Brigance Inventories (appropriate scale)
- Classroom Reading Inventory (Silvaroli)
- Diagnostic Reading Test
- Durrell Analysis of Reading Difficulty
- Gates-McKillop Reading Diagnostic Test
- Gilmore Reading Test
- Gray Oral Reading Test
- Slosson Reading Inventory
- Woodcock Reading Mastery Test

(4) written expression

(a) visual/motor perception (one required)

- Bender Visual-Motor Gestault Test (Koppitz scoring or Watkins scoring for LD)
- Bruininks-Oseretsky Motor Development Scale
- Developmental Test of Visual-Motor Integration
- Motor-Free Test of Visual Perception
- Purdue Perceptual Motor Survey
- Slosson Drawing Coordination Test for Children and Adults
- Southern California Sensory Integration Tests
- Test of Motor Impairment

(b) spelling/grammar (one required)

- Gates-Russell Spelling Diagnostic Test
- Kottemeyer Test of Written Spelling
- Larsen-Hammill Test of Written Expression

- Larsen-Hammill Test of Written Spelling
- Lincoln Diagnostic Spelling Test
- Picture Story Language Test (of written language)
- Spellmaster: Spelling, Testing, and Evaluation

(5) mathematical calculations and mathematic reasoning

- Brigance Inventories (appropriate scale)
- Diagnostic Chart for Fundamental Processes in Arithmetic
- Key Math Diagnostic Arithmetic Test
- Stanford Diagnostic Arithmetic Test

6. vocational

- General Aptitude Test Battery
- Reading-Free Vocational Interest Inventory
- Vocational Interests and Sophistication Assessment
- Wide-Range Employment Sample Test

V. EVALUATION DATA ANALYSIS

The preceding evaluation instruments are to be utilized to determine eligibility for special education services and to provide input for programming considerations. If evalulation data indicate that eligibility for services exists, the examiner should provide the Evaluation Committee with his/her opinion of what these indications suggest and offer specific programming recommendations to be implemented in the classroom.

It is the responsibility of the evaluation committee to determine eligibility and the existence of an educational deficit and to ensure that programming recommendations are incorporated in the Individual Education Program (IEP) of the student.

It then becomes the responsibility of the classroom teacher to develop sequential daily lesson plans that are consistent with IEP objectives and annual goals. The classroom teacher should closely monitor student progress to determine the appropriateness of goals and objectives and schedule a review conference when program modifications are required.

As stated earlier, there are a number of indicators that suggest the existence of a "process deficit" which may or may not be the result of a "Specific Learning Disability".

Information gathered from the individual intelligence test provides two variables to review. First, a majority of the time there will be a discrepancy between the performance scale and the verbal scale on the Wechsler test. Second, the intelligence test profile of subskills will

usually show evidence of irregular patterns of development of mental growth.

Another indicator centers around the academic achievement of the learner. A significant difference exists between the learner's level of academic performance and measured potential or capability for learning.

A consistency usually emerges in specific disorders in the broad areas of perception, memory, thinking, or perceptual motor integration functions. Tests which measure learning processes will reveal that the learner being evaluated will demonstrate a pattern of dysfunction in one or more of these skills. For example, an analysis of the tests and informal screening methods may reveal visual perceptual difficulties.

Less consistent but still an indicator is the learner's different levels of performance in the school subjects. The learner may be quite proficient and working at grade level in arithmetic, while at the same time be essentially a non-reader and have real difficulty with spelling. However, it is not uncommon to find that a learner is having difficulty in all school subjects.

Behaviors displayed by children with specific learning disabilities are the most inconsistent indicators. However, the following general categories are the most often observed in a learner who has been identified as having a specific learning disability:

- hyperactivity/attentional deficit disorder
- emotional instability
- impulsivity
- distractibility

VI. PROGRAMMING CONSIDERATIONS

Because of the wide discrepancies which exist within the specific learning disabilities category, the theories which have evolved, etc., programs have been many and varied. At one time most programs for children with specific learning disabilities were founded upon an approach, i.e. perceptual-motor, language development, etc. Today, there is a trend to move teaching away from basing a program on one approach to the development of a program based upon the individual needs of the learner. This approach of an individualized instructional program means that each student can be served regardless of the degree of involvement of the specific learning disability, educational delivery model, or age level of the learner.

Five steps are involved in this process and each of these steps are broken down into substeps. The steps are:

1. Task Analysis - the objective of the task analysis is to identify in detail what the learner must possess in order to perform the task.

2. Criterion Measurement - behavioral specifications which are used to determine whether or not a student is able to accomplish the task at a particular performance level.

3. Objectives - a behavioral description of a student's behavior after instruction. These statements must be measurable, stated in terms of student behavior, and state the condition under which the behavior will be performed.

4. Instructional Sequences - selection of procedures and materials is made to teach the skills identified in the task analysis.

5. Evaluation and Revision - determine success of the learner, determine needed revisions based on results of the evaluation, make appropriate revisions.

This approach to programming requires the educator to have an indepth knowledge of learning theory, knowledge of curriculum content, knowledge of instructional materials, knowledge of management systems, etc.

A. Academic:

Numerous instructional programs have been developed for students who have specific learning disabilities. It is the responsibility of the educator to review and evaluate the programs for appropriateness and effectiveness. Listings of programs and accompanying materials for each of the subject areas can be obtained from individuals who have specialized training in specific learning disabilities, from textbooks, professional organizations, etc. Because these children have often encountered difficulty with materials used in regular classes, modifications are necessary. For example, it is doubtful the student will encounter success with the regular basal reader. However, with the reader put on tape, the student will be able to use that material in addition to others. This is especially necessary if the student is to remain in the regular classroom. Many simple modifications exist for students who have difficulties with the regular materials. For example, a student who has difficulty with writing can make use of a typewriter or tape recorder. Printed materials can be put on tape. Calculators assist

the student having difficulty in arithmetic, and digital watches are helpful in being on time. The modifications which can be made are many and varied. These modifications must be based upon the individual learning needs of the students.

B. Social:

Since these children do not have physical signs which indicate a learning problem, they are often expected to perform at a level beyond their measured ability level. Because they cannot meet these expectations they have often developed behaviors which allow them to keep their problems hidden. These behaviors may include disruptive, anti-social behaviors. Underlying these behaviors are students with very low self-concepts. Commercial programs which assist students in understanding themselves and how to get along with others are available for the classroom.

Although these programs serve a purpose, they are not the complete solution. The solution rests with the teacher's attitude and skill in being able to work and provide for these students.

C. Communicative Abilities

The remediation of language deficits among children with a specific learning disability often requires the services of a language specialist specifically trained in this area. Nevertheless, there are principles which teachers can adhere to in working with these students. These include allowing the student time to say what he/she means when unable to express ideas verbally, showing interest in what the student is trying to say, restructuring questions and comments in order that the student may better comprehend intended meaning, etc. Emphasis should be upon a team approach for remediation of the language deficit.

D. Physical:

Because students with specific learning disabilities are often poorly coordinated they often reject becoming involved in physical activities. The major focus of the physical education program should be one that allows the individual to meet success. These students should be encouraged to participate with other students but not to compete beyond their capabilities. Remedial training programs are available for developing motor skills.

Through the utilization of program modifications, the appropriate use of support services, etc., many children are being served in the regular classroom. The goal of the educational program should be to provide services to as many students as possible in a setting with regular classroom peers.

SPEECH IMPAIRED

I. DEFINITION

The definition given under P.L. 94-142 is as follows: "Speech Impaired" means a communication disorder, such as stuttering, impaired articulation, a language impairment, or a voice impairment, which adversely affects a child's educational performance.[18]

The operational definition under Arkansas regulations, which is designed to be compatible with the Federal definition, is as follows: "Speech Impaired" means a communication disorder such as deviant articulation, fluency, voice, and/or comprehension and/or expression of language, spoken or written, which impedes the student's acquisition of basic cognitive and affective performance skills as established by the Arkansas Department of Education in Basic Educational Skills (1980).

II. POSSIBLE REFERRAL CHARACTERISTICS

A. Intellectual:

- intellectual functioning is not as strong an indicator as are other referral characteristics

B. Academic:

- overall achievement is below expectancy in relation to chronological age, mental age, or both
- achievement in reading, spelling, written composition, grammatical usage, or math processes is below expected levels, often with delay or difficulty in acquisition of pre-reading or other readiness skills
- achievement and/or intelligence test score patterns may indicate poorer skills in verbal than nonverbal areas, although not always
- word knowledge is below expectancy
- word substitutions occur frequently in reading and in writing from copy or reproducing from recall

C. Behavioral:

- hesitates or refuses to participate in verbal activities; remains mute
- is inattentive, distractible; exhibits poor concentration; has difficulty "tuning in" to tasks or switching tasks
- displays refusal behavior and/or low frustration tolerance
- perseverates verbally and/or motorically
- has difficulty following directions; must be "shown" what to do
- has trouble analyzing/integrating information from what is seen, heard, or felt
- is embarrassed or disturbed by his speech, regardless of age
- has difficulty interpreting emotions, attitudes, and intentions others communicate through nonverbal aspects of communication (facial expressions and body language)
- responds inappropriately to subtle nonverbal social cues, often giving inappropriate social responses
- does not establish or maintain eye contact
- repeats what is said to him or what he is reading, vocally or subvocally
- uses gestures extensively while talking or in place of speech

- is slow to respond during verbal interaction or following verbal cues

- is compulsive in actions or speech

- acts impulsively, without forethought; often responds before instructions are completed

- is echoic

- has difficulty remembering and finding specific words to use during conversation or when answering a question

D. Communicative Abilities:

- refer to other sections within Referral Characteristics for additional traits

- asks questions and/or responds to questions inappropriately (especially "wh" and "how" question forms)

- has difficulty discriminating likenesses and differences

- has difficulty analyzing and synthesizing sound sequences, forming stable phoneme/grapheme associations, and segmenting words into smaller grammatical units

- has difficulty learning and applying concepts of time, space, quantity, size, proportion and measurement

- has difficulty comprehending and using linguistically complex sentences

- has problems acquiring and using grammatical rules and patterns for word and sentence formation

- cannot identify pronouns and their antecedents

- cannot relate the events in a story or information in a report in sequential order

- cannot predict outcomes, make judgments, draw conclusions or generate alternatives after appropriate discussion

- does not recognize and understand figurative language such as similes, metaphors, idioms, personification, alliteration

- does not recognize syllabication and accent in words

- cannot give clear and appropriate directions

- has difficulty interpreting or formulating (oral or written) compound or complex sentences, sentences which compare and contrast ideas or show cause-effect relationships

- cannot summarize essential details from hearing or reading a passage, nor distinguish relevant from irrelevant information

- has difficulty analyzing and solving math reading problems of various complexity (one or multiple step), including those involving probability

- will not initiate conversations

- cannot identify or use expository, descriptive or narrative language in written work

- cannot write an organized paragraph using related sentences of varying length and grammatical complexity

- has problems interpreting and/or using vocal pitch, intensity, and timing for purposes of communicating subtle distinctions in emotion and intention

- has inappropriate vocal pitch for age and sex

- does not use appropriate vocal control, particularly in regulating speaking volume (unusually loud or soft)

- has breathy, harsh, husky, or monotone voice

- continually sounds congested (denasal)

- sounds unusally nasal; voice has a "whining" quality

- has abnormal rhythm or rate of speech

- frequently prolongs or repeats sounds, words, phrases and/or sentences during speech

- has unintelligible (cannot be understood) or indistinct speech

- has difficulty articulating sounds within words

E. Physical:

- conditions are indicated in the student's medical/developmental history, such as: cleft lip and/or palate, deviant palatal-pharyngeal structure, cerebral palsy, muscular dystrophy, brain injury, aphasia, vocal nodules or other pathology of the vocal mechanism, hearing loss, myringotomy or other aural surgery, orofacial abnormalities, congential disorders

- has continuous allergy problems or frequent colds

- has deviant dental structure

- has oral muscular coordination slower than normal

- displays clumsiness or general motor incoordination

III. SCREENING INFORMATION - (Refer to page eleven-one (11-1) for definition of Screening)

A. Required:

- hearing

- vision

B. Recommended:

1. Formal

- Information derived from school-wide, grade and/or class testing may be utilized

2. Informal

- checklists

- inventories

- rating scales

- interviews

- observation in the classroom and/or other settings

- access to and review of existing records and available information

IV. REQUIRED EVALUATION DATA - (Refer to page eleven-three (11-3) for definition of Evaluation)

A. Social History:

1. Educational

2. Family (using language of the home)

3. Medical

B. Assessment:

1. Individual intelligence (required when language disorder is suspected; otherwise not applicable unless requested)

- Leiter International Performance Scale

- appropriate Wechsler Scale

  - Wechsler Adult Intelligence Scale (WAIS) (16 + years)

  - Wechsler Adult Intelligence Scale - Revised (WAIS-R)

  - Wechsler Intelligence Scale for Children-Revised (WISC-R) (6-16 years)

  - Wechsler Preschool and Primary Scale of Intelligence (WPPSI) (4-6 1/2 years)

2. Individual achievement test (required when language disorder is suspected; otherwise not applicable unless requested)

   - Peabody Individual Achievement Test (PIAT) (K-12 grades)

   - Stanford Achievement Test (individually administered) (1.5 - 9.5 grades)

   - Wide Range Achievement Test (WRAT) (K-12 grades)

   - Woodcock-Johnson Psychoeducational Battery (3-'0 + years)

3. Adaptive behavior (not applicable unless requested)

   - AAMD Adaptive Behavior Scales, Public School Version (5-11 years)

   - Adaptive Behavior Inventory for Children (ABIC)

   - Alpern-Boll Development Profile

   - Pupil Rating Scale

   - Vineland Social Maturity Scale

4. Communicative Abilities

   The appraisal for and diagnosis of a specific communication disorder is the responsibility of a qualified speech-language pathologist. This professional will evaluate students using procedures appropriate to assessment and diagnosis of specific communication disorders. When, in the opinion of the speech-language pathologist, it is deemed necessary to have additional evaluations, referral of students may be made for such assessment(s). This may include referral for medical and/or other professional evaluation. The speech-language pathologist will include such additional information in the process of formulating diagnostic and/or programmatic impressions.

   The speech-language evaluation is basic to determining the nature and extent of a communication disorder. In order to accurately judge these features it will be necessary to assess related functions which may contribute to or underlie a communication disorder. For example, impaired articulation may be related to an auditory acuity and/or perceptual deficit, a motor-speech problem, overall maturational lag, or deviant oral structure. Such determinations cannot be made solely through administration of a standard test of articulatory ability. Related functions must be considered.

Comprehensive assessment of a student's communicative abilities includes a description of the status and function of orofacial structures. An oral peripheral speech mechanism examination is therefore a required component of evaluation. The speech mechanism evaluation must be conducted in addition to the administration of two or more tests and/or procedures which delineate the specific nature of the disorder.

Non-diagnostic instruments are utilized with individual students to determine the need for in-depth assessment within the areas of language, articulation, voice, fluency and/or perception and processing. Diagnosis as to the nature and/or extent of the disorder(s) cannot be based on the results gained from non-diagnostic instruments.

a. Language. A language disorder is the impairment or deviant development of comprehension and/or expression of spoken or written language. Such disorders may involve one, all or a combination of the following components of a language system.

1) Phonology involves the sound system of a language; the particular sounds of the sound system and the ways in which the rules of a language permit them to be combined. Phonologic disorders are most often articulatory and are addressed under Articulation.

2) Morphology involves the structure of words and the ways in which the rules of a language permit the construction of new word forms, such as combining "root" words with prefixes and suffixes, or compounding words.

3) Syntax involves the rules governing the order and combination of words in the formation of sentences, and the relationships among the elements within a sentence or between two or more sentences.

4) Semantics is the psycholinguistic system that patterns individual word meanings and the combining of word meanings to form the content of a sentence.

5) Pragmatics is the sociolinguistic system that patterns the use of language in context.

Prosody is a feature of communication involving stress and intonation patterns that convey the meaning of spoken utterances, determined primarily by variations in pitch, loudness and duration. Systematic observation of these elements can be made during language assessment.

Non-diagnostic

- Assessment of Children's Language Comprehension (ages 3-6 years)

- Bankson Language Screening Test (ages 4-7 years)
- Basic Concept Inventory (Preschool-primary grades)
- Boehm Test of Basic Concepts (grades K-2)
- Clinical Evaluation of Language Functions Screening Tests (grades K-12)
- Fluharty Preschool Speech & Language Screening Test (ages 2-6 years)
- Meeting Street School Screening Test (ages 5-7 1/2 years)
- Northwestern Syntax Screening Test (ages 3-8 years)
- Preschool Language Scale-Revised (ages 18 months - 7 years)
- Screening Test for Auditory Comprehension of Language (ages 3-6 years)
- Screening Test of Adolescent Language (Jr. & Sr. High)
- Utah Test of Language Development (ages 1 - 15 years)
- Vocabulary Comprehension Scale (ages 2-6 years)

Diagnostic

- Carrow Elicited Language Inventory (ages 3-7 years)
- Clinical Evaluation of Language Functions Diagnostic Battery (grades K-12)
- Detroit Test of Learning Aptitude (ages 3-19 years)
- Fullerton Language Test for Adolescents, Exp. ed. (ages 11 years-adult)
- Illinois Test of Psycholinguistic Abilities (ages 2-10 years)
- Minnesota Test for Differential Diagnosis of Aphasia
- Peabody Picture Vocabulary Test
- Peabody Picture Vocabulary Test-Revised (ages 2 1/2 - 40 years)
- Picture Story Language Test (Written Language) (ages 7-17 years)
- Porch Index of Communicative Ability in Children (ages 3-12 years)
- Reading Comprehension Battery for Aphasia (adolescents-adults)
- Structured Photographic Language Test (ages 4-8 years)
- Systematic observation of language behavior in conversational speech
- Test of Auditory Comprehension of Language (ages 3-6 years)
- Test of Adolescent Language (grades 7-12)
- Test of Concept Utilization (ages 4 1/2 - 18 1/2 years)
- Test of Language Development (ages 4-8 years)
- Test of Syntactic Abilities (ages 10 - 18 years)
- Test of Written Language (ages 7-14 1/2 years)
- The Token Test for Children (ages 4-12 years)
- The WORD Test (ages 7 + years)

b. Articulation. An articulation disorder is the abnormal production of speech sounds.

Non-diagnostic

- Photo Articulation Test (ages 3-12 years)

- Predictive Screening Test of Articulation (grade 1)
- Screening Deep Test of Articulation (ages Preschool-Adult)
- Screening Test for Developmental Apraxia of Speech (ages 4-12 years)

Diagnostic

- Apraxia Battery for Adults (adolescents-adults)
- Arizona Articulation Proficiency Scale-Revised (ages 3-11 years)
- Distinctive Feature Analysis of Misarticulations
- Fisher-Logemann Test of Articulation Competence
- Goldman-Fristoe Test of Articulation
- Iowa Pressure Articulation Test
- Ling Phonetic Speech Evaluation
- McDonald Deep Test of Articulation (ages Preschool - Adult)
- Motor Speech Disorders text, clinical tasks
- Ohio Tests of Articulation & Perception of Sounds (ages 5-8 years; grades K-3)
- Procedures for the Phonological Analysis of Children's Language
- Templin-Darley Test of Articulation
- Fletcher Time by Count Test of Diadochokinetic Syllable Rate (ages [illegible]-13 years)
- Weiss Comprehensive Articulation Test (Preschool +)

c. Voice. A voice disorder is the absence or abnormal production of voice characterized by deviant initiation/duration, tonal quality, pitch, loudness, and/or resonance.

- Children's Voice Disorders, F. Wilson text, clinical tasks
- Clinical Voice Disorders: An Interdisciplinary Approach, Aronson text, clinical tasks
- Modern Techniques of Vocal Rehabilitation, M. Cooper text, clinical tasks
- The Boone Voice Program For Children, diagnostic components (Grades K-6)
- The Voice and Voice Therapy, Boone text, clinical tasks
- Voice Problems of Children, D. K. Wilson text, clinical tasks
- Wilson Voice Profile

d. Fluency. A fluency disorder is the abnormal flow of verbal expression characterized by impaired rate and rhythm which may be accompanied by struggle behavior.

- Fluency Assessment Battery
- Iowa Scale of Attitude Toward Stuttering
- Parental Diagnostic Questionnaire
- Programmed Therapy for Stuttering In Children and Adults, Ryan text
- Stuttering Severity Instrument: Riley Scale (school children & adults)
- Stuttering Theory and Treatment, Wingate text
- Stuttering: Therapy for Children, Luper & Mulder text (adolescents)

- The Disfluent Child: A Management Program, Zwitman text
- The Stocker Probe Technique (children)

e. Perception and Processing. A perceptual and/or processing disorder is characterized by deviant attention, sequencing, memory, analysis, synthesis, and/or discrimination abilities.

Non-diagnostic

- Flowers Auditory Test of Selective Attention (school age)
- Test of Nonverbal Auditory Discrimination (primary children)
- The Testing-Teaching Module of Auditory Discrimination

Diagnostic

- Auditory Integrative Abilities Test
- Auditory Pointing Test (grades K-5)
- Denver Auditory Phoneme Sequencing Test (children-adults)
- Flowers-Costello Tests of Central Auditory Abilities
- Goldman-Fristoe-Woodcock Auditory Memory Tests (children - adults)
- Goldman-Fristoe-Woodcock Auditory Selective Attention Test
- Goldman-Fristoe-Woodcock Auditory Sound-Symbol Tests (ages 3-80 years)
- Language-Structured Auditory Retention Span Test (ages 3 years-adult)
- Lindamood Auditory Conceptualization Test (preschool-adult)
- The Tree/Bee Test of Auditory Discrimination (ages 3-9 years)
- Visual Aural Digit Span Test (ages 5-12 years)
- Washington Speech Sound Discrimination Test (ages 3 years-K. level)
- Willeford Battery of Central Auditory Processing Skills (ages 5 years-adult)

V. EVALUATION DATA ANALYSIS

In analyzing communicative abilities, the examiner should be aware of factors which represent communication differences rather than disorders. Communication differences refer to maturational, regional, social or cultural/ethnic speech and/or language variations that are not considered communication disorders.

After analyzing the evaluation data pertaining to the student's communicative abilities, the speech-language pathologist will submit the information to the committee in the form of a written report. Through committee interaction this evaluation information will be integrated with all other data (screening information; teacher observations, including those of educational performance; and other formal and informal assessment data) gathered throughout the screening/evaluation processes. This will be done so that the committee may determine if a handicapping condition exists which impedes the student's acquisition of expected cognitive and

affective performance goals. The committee must judge what the consequences of the impairment are for the child in relation to expected learnings within the curriculum, as established at each grade and/or chronological age level of skill development. The relationship of the communication disorder to expected learnings should be recorded on the Evaluation Conference Decision form. Once the deficit is established, a determination must be made of the corresponding need for special education services.

When it is determined that a student with a primary handicap other than "Speech Impaired" manifests a secondary handicap within the area of communicative abilities, circumstances then exist for the provision of speech and/or language services. Additionally, such services may be considered for the student whose primary handicap is in another category when there is strong reason to believe that the student's progress will be impeded without such intervention.

VI. PROGRAMMING CONSIDERATIONS

A judgment must be made regarding the severity of the disorder so that the individual education program addresses student needs in relation to the nature and extent of the handicapping condition. Analysis of the evaluation information serves as the basis for a determination of severity and programmatic strategies. It will be necessary to make adjustments in caseload size (total number of students served) in order to provide appropriate programming for students requiring more intensive services. The guideline for such adjustments is stated on page four-one (4-1) of the Program Standards Section.

VISUALLY HANDICAPPED

I. DEFINITION

"Visually Handicapped" means a visual impairment which, even with correction, adversely affects a child's educational performance. The term includes both partially seeing and blind children.[19]

Visually impaired pupils are those who because of the type and degree of visual impairment are unable to perform satisfactorily in the usual classroom without significant modifications in curriculum and instructional materials, equipment, and methods. Special education for the visually impaired may be offered specifically for low vision pupils, for blind pupils, or for low vision and blind pupils in combination. Special classes may be conducted at either elementary or secondary level. Itinerant services may enroll either elementary or secondary pupils, or both.

II. POSSIBLE REFERRAL CHARACTERISTICS

Low vision pupils are those whose vision, although impaired, is yet the primary channel of learning and, with considerable adjustments, are able to perform the visual tasks required in the usual school situation. Generally, their visual acuity with correction is 20/70 or less.

Blind pupils are those with no vision or with little potential for developing vision as a primary channel for learning and; therefore, must rely upon tactual and auditory senses to obtain information.

Visually impaired pupils include both blind and low vision pupils.

Visually impaired, multihandicapped pupils are those who are mentally retarded, brain injured, physically handicapped, emotionally and/or socially disturbed, hearing impaired, or non-verbal, as well as low vision or blind.

A. Intellectual:

- shows approximately the same distribution of scores on intellectual tests as the seeing individual, when tests such as auditory-vocal or haptic-motor channels of communication are used

B. Achievement:

- has relatively normal educational achievement
- tend to achieve more poorly in subjects such as mathematics

C. Behavioral:

- appears "clumsy", especially in a new situation
- holds head in an awkward position to look at something or holds a book or other objects in a peculiar position to look at them
- "tunes out" when information is on the chalkboard or in a book which the student cannot read

- constantly asks a neighbor to tell him/her what is going on
- shows signs of fatigue or inattentiveness
- exhibits poor self-concept and ego development

D. Communicative Abilities:

- less effective use of gesture and bodily action
- uses less lip movement in the articulation of sounds

E. Physical:

The National Society for the Prevention of Blindness suggests the following signs of possible eye problems in children:

1. Behavior
   - rubs eyes excessively
   - shuts or covers one eye, tilts head or thrusts head forward
   - has difficulty in reading or in other work requiring close use of the eyes
   - blinks more than usual or is irritable when doing close work
   - holds books close to eyes
   - is unable to see distant things clearly
   - squints eyelids together or frowns
2. Appearance
   - crossed eyes
   - red-rimmed, encrusted, or swollen eyelids
   - inflamed or watery eyes
   - recurring styes
3. Complaints
   - eyes itch, burn or feel scratchy
   - cannot see well
   - dizziness, headaches, or nausea following close eye work
   - blurred or double vision

III. SCREENING INFORMATION

A. Required:

- hearing
- vision (to include distance vision and near point vision)

B. Recommended: Either/or a combination of formal and informal data

1. Formal

Screening through a low vision clinic is recommended.

2. Informal

- observation

- checklist

IV. REQUIRED EVALUATION DATA

A. Social History

1. Educational

2. Family (using language of the home)

3. Medical including an evaluation by an eye specialist conducted within the past year, comprised of visual acuity, refractive errors, prescription correction where indicated, etiology, prognosis and low vision evaluation.

B. Assessment:

1. Individual intelligence (recommended for visually imparied children, but not required)

- Perkins-Binet

- Wechsler Scale - verbal

2. Individual achievement (one required) - available in large print and braille

- Cooperative Sequential Test of Educational Progress

- School and College Ability Tests

- Stanford Achievement Test

- Brigance Inventories

- comprehensive criterion - referenced achievement measures

3. Adaptive behavior (one required)

- AAMD Adaptive Behavior Scale

- Pupil Rating Scale

- Vineland Social Maturity Scale

4. Communicative Abilities assessment (one required)

- See suggestions in "Speech Impaired" Section

5. Other (optional)

a. Orientation and Mobility assessment:

- Basic Concepts

- Body Awareness

- other areas as appropriate

b. sensory and learning processes

- Language - Structured Auditory Retention Span Test (ages 3 years - adult)

- Roughness Discrimination Test

- Visual Efficiency Scale

c. specific subject areas

(1) reading

- Botel Reading Inventory
- Diagnostic Reading Test
- Durrell Analysis of Reading Difficulty
- Gates-McKillop Reading Diagnostic Test
- Gilmore Reading Test
- Gray Oral Reading Test
- Woodcock Reading Mastery Test

(2) arithmetic

- Diagnostic Chart for Fundamental Processes in Arithmetic
- Diagnostic Tests and Self-Helps in Arithmetic
- Key Math Diagnostic Arithmetic Test
- Stanford Diagnostic Arithmetic Test

(3) spelling

- Gates-Russell Spelling Diagnostic Test
- Lincoln Diagnostic Spelling Test
- Spellmaster: Spelling, Testing, Evaluation

d. vocational

- General Aptitude Test Battery
- Reading-Free Vocational Interest Inventory
- Vocational Interests and Sophistication Assessment
- Wide-Range Employment Sample Test

V. In addition to the content of the subject areas, visually impaired children are expected to learn specific compensatory skills enabling them to compete successfully in school. They need to learn how to read material in a variety of formats--braille, large print, talking books, tape recordings and other electronic reading aids. The typewriter provides them with a tool for communicating directly with the sighted child or adult. Mathematical computations are most easily performed on an abacus or electronic aid. Orientation and mobility skills are developed with years of training and practice. The visually impaired child is also expected to learn how to use adapted educational supplies and equipment such as relief maps, special measurement equipment, timers and light sensors. When a trained teacher of visually impaired children provides adequate instruction in these support areas, the visually impaired child can and does compete very successfully in the regular classroom.

VI. PROGRAMMING CONSIDERATIONS

As stated earlier, effects of visual impairment vary depending on the severity of the impairment, age of onset of impairment, developmental opportunities, and the type and degree of any other handicap. These factors and a combination of these factors result in a various heterogeneous group of students. Because of this heterogeneity, educational programs must be individualized. The educational program must be built upon the use of concrete, not abstract teaching methods, stress the relationship among things in the environment, and be built on deliberate planning.

Visually impaired students often need a variety of special educational materials. Some of the materials and equipment include:

- large-type readers
- recorded books
- braillewriters or braille slates and stylus
- non-glare writing paper ruled in bold, wide lines
- APH Speech Plus calculator - gives results of the calculation process in both visual and auditory form
- Optacon - a device that translates printed visual symbols into tactile configurations that can be perceived by touch
- Kurzweil Reading Machine - device that translates print into auditory output
- closed-circuit television systems - permit display of print on a TV screen in almost any size

The American Printing House for the Blind is one resource for educational materials.

A. Academics:

Many visually impaired students can achieve quite successfully in the academic area. Provision needs to be made for presenting information in the most concrete method possible. Concept formation is essential and every provision possible should be made to ensure proper concept formation.

B. Mobility:

Orientation and mobility, basic concepts, body image and spatial awareness instruction begins as early as possible, continuing through the elementary grades. Mobility or independent travel with the white cane should begin no later than the early secondary grades and continue until graduation. A specially trained and certified orientation and mobility instructor is needed for mobility instruction.

C. Social:

The visually impaired student needs direct instruction in social skills which other

students might learn incidentally. Because these students are frequently viewed negatively by others it is important the visually impaired student enhance his/her appearance and display adequate social skills.

D. Communicative Abilities:

Major emphasis in the area of language is the use of facial and body gestures appropriately.

E. Physical:

Students need to acquire skills which will help them become active participants. As much as possible they should take part in the physical education programs.

FOOTNOTES

[1]Arkansas Legislature, State of, "Arkansas Statutes: Act 129," Statutes Book (Arkansas: Bobbs-Merrill, 1955), Section 2.A.

[2]Arkansas Legislature, op. cit., Section 2.B.

[3]Health, Education, and Welfare, Department of, Office of Education, "Education of All Handicapped Children's Act of 1975" (Public Law 94-142), Federal Register, Vol. 42, No. 163 (Washington: U. S. Government Printing Office, August 23, 1977), Section 121a.550.

[4]Health, Education, and Welfare, op. cit., 121a.13

[5]Health, Education, and Welfare, op. cit., 121a.532.

[6]Health, Education, and Welfare, Department of, Office of Education, "Procedures for Evaluating Specific Learning Disabilities," Federal Register, Vol. 42, No. 250 (Washington: U.S. Government Printing Office, December 29, 1977), Section 121a.543.

[7]Health, Education, and Welfare, op. cit., 121a.5.

[8]Rapin, Isabelle et al: "Otitis Media and Child Development: Speech, Language and Education." The Annals of Otology, Rhinology, and Laryngology Supplement 60-Vol. 88, Sept. Oct., 1979 No. 5, Part 2.

[9]Health, Education, and Welfare, op. cit., 121a.5.

[10]Norris G. Haring, Behavior of Exceptional Children (Columbus: Charles E. Merrill Publishing Company, 1978), p. 121.

[11]Health, Education, and Welfare, loc. cit.

[12]June Bigge and Barbara Siruis, "Children with Physical and Multiple Disabilities," Behavior of Exceptional Children (Norris F. Haring ed., Columbus: Charles E. Merrill Publishing Company, 1978), p. 384-386.

[13]Health, Education, and Welfare, loc. cit.

[14]Health, Education, and Welfare, loc. cit.

[15]Cartwright, Carol A., Cartwright, G. P., "Competencies For Prevention Of Learning Problems In Early Childhood Education," Education Horizons, 1975.

[16]Bill R. Gearheart and Mel. W. Weishahn, The Handicapped Student in the Regular Classroom (St. Louis: The C. V. Mosby Company, 1980), p. 221.

[17]Health, Education, and Welfare, loc. cit.

[18]Health, Education, and Welfare, loc. cit.

[19]Health, Education, and Welfare, loc. cit.

DESCRIPTION OF TESTS

The following annotations of all tests listed in this document are provided to give basic information about tests being considered for use with students. Included in each annotation is a code as to who may administer said test. It is essential that persons administering tests be familiar with the test and with testing principles so as to ensure valid test results. It is recommended that in-service be provided to all persons administering tests to include: testing procedures and scoring.

The key to the code of persons who may administer tests is as follows:

A - educational examiner
B - teacher, counselor
C - psychological examiner
D - speech pathologist
E - psychologist
F - parent
G - occupational and physical therapists

This code is not to be considered totally inclusive of all eligible to administer a specific instrument. There may be persons qualified to use the instruments other than those indicated.

AAMD ADAPTIVE BEHAVIOR SCALES

These scales were designed to follow the definition of adaptive behavior of the American Association on Mental Deficiency. The scales include 111 items covering 24 areas of personal and social behavior. The scales may be used with students from 3 years of age through adult and may be completed by an individual who is well acquainted with the subject. Its major purpose is to assist in evaluating the effectiveness of an individual in "coping with the natural and social demands of his/her environment".

A, B, C, D, E, F

ADAPTIVE BEHAVIOR INVENTORY FOR CHILDREN

The ABIC is a series of age-graded questions relating to the child's role performance in the family, adaptive behavior in the neighborhood, skill in interpersonal relations, ability to care for his or her own physical needs, and the like. Responses to the ABIC may be hand scored. It is appropriate for ages 5-11 years.

ALPERN-BOLL DEVELOPMENTAL PROFILE

This instrument consists of 217 items which tap five separate areas: physical development, self-help, social development, preacademic and academic skills, and communication skills. Age-equivalent scores can be obtained in each of the five areas as well as an overall developmental index.

A, B, C, D, E, F

APRAXIA BATTERY FOR ADULTS

The ABA is an individually administered set of tasks designed to measure the presence and severity of apraxia in adolescents and adults. It consists of six subtests including: Diadochokinetic Rate, Increasing Word Length, Limb and Oral Apraxia, Latency and Utterance Time for Polysyllabic Words, Repeated Trials Test, and Inventory of Articulation Characteristics of Apraxia. Administration requires approximately 20 minutes.

D

ARIZONA ARTICULATION PROFICIENCY SCALE - REVISED

The AAPS is an individually administered instrument designed to provide a rapid and precise determination of misarticulations and of total articulatory proficiency. It provides a numerical scale of articulatory proficiency by weighting misarticulations according to the frequency with which a particular sound occurs in speech. The AAPS provides both a picture and a sentence version, which test consonants and vowels. Yields score which can be interpreted according to a scale of severity and to categories of intelligibility. Standardized for ages 3 to 11 years.

D

ASSESSMENT OF BASIC COMPETENCIES

This is a new battery of tests which has been specially designed for the diagnostic assessment of children who manifest school learning problems. Three domains are assessed: Information Processing, Language and Mathematics. Each test in the battery was designed to measure competency from preschool to about Grade 9. Data for calibration norming, validity, and reliability are presented in the manual.

A, B, C, D, E

ASSESSMENT OF CHILDREN'S LANGUAGE COMPREHENSION (ACLC)

The ACLC is an individually administered tool for normal and handicapped children which measures a preschool child's comprehension of critical elements (nouns, verbs, modifiers, and spatial concepts). The test utilizes a core vocabulary of fifty common words combined into 2-, 3-, and 4- element phrases. The child is required to point to the appropriate picture indicated by the stimulus word or phrase. The ACLC is essentially a criterion-referenced instrument (Mean scores for 6-month age groups from 3 years to 6 years, 5 months are provided.), which can be administered in 10 to 15 minutes.

D

AUDITORY INTEGRATIVE ABILITIES TEST

A simple, concise, reliable assessment of auditory perception disorders as they relate to language and learning disabilities. Utilizes non-verbal stimuli to test in three skill areas: Auditory - Motor, Auditory-Graphic, and Auditory-Verbal. The Examiner's Manual gives pretest instructions as well as scoring methods and interpretative data.

D

AUDITORY POINTING TEST

This is a diagnostic test of short-term memory paired with a visual-motor response (pointing) for administration to individual students in grades K-5 (normed) and older, through adults (not normed). The child is presented with stimulus picture cards and asked to point to the item said by the examiner. Scoring is on the basis of items-correct-to-ceiling, with conversion tables for raw scores.

A, B, C, D, E

AUTISM SCREENING INSTRUMENT FOR EDUCATION PLANNING

Information not available at time of printing

AYRES TESTS OF MOTOR AND PERCEPTION

A series of tests published as the following:

Southern California Kinesthesia & Tactile Perception Test, 1966
Southern California Motor Accuracy Test, 1964
Southern California Figure-ground Visual Perception Test, 1966
Ayres Space Test, 1962
Southern California Perceptual Motor Tests, 1965-1969

All are designed for use with young children, mostly from age 3 or 4 to around age 8 to 10. They are clinical devices intended to evaluate dysfunction in various neuromuscular and perceptual areas. However, reliability co-efficients are too low to be used diagnostically. Developed by Ayres, an occupational therapist, most norms are given in terms of standard scores for age levels.

A, C, E, G

BALTHAZAR SCALES OF ADAPTIVE BEHAVIOR FOR THE PROFOUNDLY AND SEVERELY MENTALLY RETARDED

Section one of the scale provides information for determining functional independence in the areas of: dependent feelings, finger foods, spoon usage, fork usage, drinking, total eating skills, total dressing, and total toileting. Section two is concerned with social adaptions and provides for a rating of: unadaptive self-directed behavior, unadaptive interpersonal behaviors, adaptive self-directed behavior, adaptive interpersonal behaviors, communication, play activities, response to instructions, and a checklist of personal care and other behaviors. The scale gives criteria for each behavior.

A, B, C, D, E, F, G

BANKSON LANGUAGE SCREENING TEST

The Bankson Language Screening Test is an individually administered instrument designed for identifying children in need of further language assessment. This test is based upon a linguistic model that includes the morphological, syntactical, and semantic aspects of language necessary for linguistic performance. It also screens auditory and visual perception. The test can be administered in about 25 minutes. Normative data are provided on children of ages 4 through 7.

A, B, C, D, E

BASIC CONCEPT INVENTORY (BCI)

The BCI is a criterion-referenced checklist of the basic concepts needed in early academic activities. Designed for use with children from preschool through primary grades. BCI reveals: (1) familiarity with basic concepts, (2) familiarity with conventional statements and ability to repeat them, and (3) ability to perceive the similarity of elements squeezed in a pattern. Especially useful with experientially-deprived and emotionally-disturbed children.

A, B, C, D, E

BAYLEY SCALES OF INFANT DEVELOPMENT

The Bayley Mental and Motor Scales consist of specific statements describing observable responses which the assessor attempts to elicit through direct interaction with the child. It is a scale which follows normal developmental sequence from 0-30 months. The accompanying Infant Behavior Record provides for ratings of qualitative aspects of infant behavior and for an overall evaluation.

A, B, C, D, E

BAYLEY SCALES OF MENTAL DEVELOPMENT

Assessment tool of sensory-motor thought processes and early language behaviors administered through use of manipulative materials. Early visual and auditory abilities receive heavy assessment emphasis.

A, C, E, G

BAYLEY SCALES OF MOTOR DEVELOPMENT

Assesses gross and fine motor skills of infants. Provides developmental age levels for skills such as head control, sitting, walking, climbing, jumping, and visual-motor integration.

B, G

BENDER VISUAL-MOTOR GESTALT TEST

Although this test is used primarily to measure visual perception abilities, it has also been used to measure social-emotional adjustment, intelligence, and brain injury. The test is composed of nine geometric figures that the student is required to draw from memory or reproduce while the stimulus is present. Forms for children from 4 to 11 years old have been developed. A trained clinical psychologist should administer and interpret the test. An alternative scoring procedure has been developed by Koppitz.

A with training and only Koppitz scoring, C, E

BEHAVIOR PROBLEM CHECKLIST

This checklist was developed by Peterson and Quay to be given by teacher, parent, or therapist. The behavior problems measured by the checklist are divided into conduct disorders, personality disorders, inadequacy and immaturity and subcultural delinquency. Best used as an observational device.

A, B, C, D, E, F, G

BOEHM TEST OF BASIC CONCEPTS

This picture test is designed for use with children in kindergarten and grades 1 and 2. It can be administered as a group or individual test. The test is intended to measure basic concepts needed to achieve in primary grades. The Boehm Test is available in 2 alternate forms. Although normative data are provided, the test should be considered criterion-referenced.

A, B, C, D, E, G

BOTEL READING INVENTORY

This battery is comprised of the following three subtests: word recognition, word opposites, and phonics mastery. The test can be used to appraise reading levels from preprimer to fourth grade. The entire battery is widely used to informally measure a student's instructional, free reading, and frustration reading levels in addition to appraising the student's phonics proficiency.

A, B, C, D, E

BOWER-LAMBERT SCALES FOR IN-SCHOOL SCREENING OF EMOTIONALLY DISTURBED HANDICAPPED CHILDREN

The purpose of this device is to screen children with potential emotional handicaps at the primary, intermediate, and secondary grade levels. A different form is provided for each of these three groups. The child rates him/herself and the teacher and peers rate the child also.

A, B, C, D, E, F

BRIGANCE DIAGNOSTIC INVENTORY OF EARLY DEVELOPMENT

Information not available at time of printing.

BRUININKS-OSERETSKY TEST OF MOTOR PROFICIENCY

The complete battery yields a broad measure of motor proficiency as well as differentiated measures of both gross and fine motor skills. The complete battery can be individually administered in an hour or less and is designed for ages 4 1/2 to 14 1/2. Criteria for scoring responses to the test items are clearly presented in the examiner's manual. Norms were developed so that useful comparisons can be made between gross and fine motor skills. Within-age standard scores, percentile ranks, and stanines are available for test interpretation. Technical information about test validity, reliability and development of norms can be found in the examiner's manual.

A, B, C, D, E

BURKS' BEHAVIOR RATING SCALES

This scale is designed to identify patterns of pathological behavior shown by children in grades one through nine. A rater who knows the child makes quantitative judgments about the degree to which behaviors are observed. A preschool and kindergarten edition is available for ages three through six. A profile is available for interpretation.

A, B, C, E

CAIN-LEVINE SOCIAL COMPETENCY SCALE

This test consists of 44 items on which behavior of the trainable mentally retarded may be rated to estimate social competence. A total score plus four subscale scores on self-help, initiative, social skills, and communication may be interpreted through percentile norms. These subscale scores are helpful in individual planning and evaluation of programs.

A, B, C, D, E, F

CALIFORNIA ACHIEVEMENT TEST

This is a group-administered, norm-referenced, multiple-skill assessment battery which measures skill development in several areas from grades 1.5 to 12. There are two forms of the test at each of the five educational levels. Skill development can be assessed in the following three academic content areas: reading, math, and language.

A, B, C, E, F

CALIFORNIA TEST OF MENTAL MATURITY

In this test memory, spatial relationships, logical reasoning, and verbal concepts are measured to determine intelligence. The test can be used with students at the kindergarten through adult level.

A, C, E

CALLIER-AZUSA SCALE

The Callier-Azusa Scale was designed specifically for deaf-blind and multihandicapped students by an interdisciplinary team who had many years experience with this population. It can be used with the most severely handicapped students and is especially valuable for students with visual and/or hearing impairments because of subscales relating to visual, auditory, and tactile development. Team approach suggested.

B, D, F, G

CAMELOT BEHAVIOR CHECKLIST

The ten major domains rated are Self-help, Physical Development, Home Duties, Vocational Behavior, Economic Behavior, Numerical Skills, Communication Skills, Social Behaviors and Responsibility. The primary methods recommended for conducting the rating are direct observation and/or actual testing of the client for the behaviors. Training objectives can be developed directly from those items which need training.

A, B, C, E

CARROW ELICITED LANGUAGE INVENTORY

The purpose of this test is to provide a means for evaluating children's (ages 3 to 7) control of grammar. Fifty-two stimuli which include 51 sentences and 1 phrase make up the test. A series of sentences are read to the child and the child is asked to imitate exactly what he/she heard, with the response taped. The grammatical categories include articles adjectives, nouns, noun plurals, pronouns, verbs, negatives, contractions, adverbs, prepositions, demonstratives, and conjunctions. The test, individually administered, requires 5 minutes to administer and 20 to 30 to score. Reliability, validity, and normative information is presented in the test manual.

D

CATTELL INFANT SCALE OF INTELLIGENCE

Instrument consisting of many manipulative items used to assess the child's abilities in problem solving, imitation, object permanence, object concept, and language skills.

A, C,, E, G

CHILDREN'S VOICE DISORDERS

Information not available at this time.

D

CELF: CLINICAL EVALUATION OF LANGUAGE FUNCTIONS-DIAGNOSTIC BATTERY

The CELF: Diagnostic Battery is an individually administered measure designed to assist in the identification of children in Grades K-12 with language disabilities; to provide a differential diagnoisis of areas of involvement including phonology, syntax, semantics, memory, and word finding and retrieval; and to identify areas for follow-up language intervention. The Diagnostic Battery is a series of 13 subtests (10 untimed, 3 timed) which are divided by Processing of: Word and Sentence Structure, Word Classes, Linguistic Concepts, Relationships and Ambiguities, Oral Directions and Spoken Paragraphs. The second division includes Producing: Word Series, Names on Confrontation, Word Associations, Model Sentences, Formulated Sentences, and Speech Sounds. The Diagnostic Battery was standardized concurrently with the standardization of the CELF Screening Tests (see CELF: Screening Tests for additional information).

A, B, C, D, E

CELF: THE CLINICAL EVALUATION OF LANGUAGE FUNCTIONS-SCREENING TESTS

The CELF: Screening Tests, Elementary and Advanced levels, are untimed, individually administered measures designed to assist in the identification of children K-12 who may need in-depth assessment of oral language functions. One set of items which present oral directions and require no verbal responses is grouped to form the processing items sections. The second set of items which present spoken stimuli and require a spoken response is grouped to form the production items sections. Test standardization data was collected on a group representative of children in grade-age range from K-12 selected according to 1) grade level, 2) sex, 3) racio-ethnic background, and 4) geographic region. Data also was collected on children's residence and occupation of parents.

A, B, C, D, E, G (and F if supervised by trained specialists or educators)

CLINICAL VOICE DISORDERS: AN INTERDISCIPLINARY APPROACH

Information not available at this time.

D

COLUMBIA MENTAL MATURITY SCALE

This individual intelligence test is designed to assess a student's reasoning ability. On the test a student has to make visual-perceptual discriminations in order to classify and relate series of pictures, colors, forms, and symbols. The 92 figural and pictorial classification items that make up the scale are arranged in eight overlapping levels and may be used with children between 3 years, 6 months and 9 years, 11 months, of age. The test can be administered in approximately 15 to 20 minutes.

A, C, E

COMMUNICATIVE EVALUATION CHART (CEC)

The CEC is a scale designed as a quick screening of a child's abilities in language and performance. The items were taken from various sources such as Gesell and Cattell and were not restandardized. Information may be obtained through an interview technique and direct observation. The chart is divided into nine age levels: 3, 6 and 9 months; 1, 1 1/2, 2, 3, 4 and 5 years of age.

A, B, C, D, E, G

CONNER'S PARENT RATING SCALE

Information not available at this time.

CONNER'S TEACHER RATING SCALE

Information not available at this time.

COOPERATIVE SEQUENTIAL TEST OF EDUCATIONAL PROGRESS (STEP) Series II

STEP Series II is a revised battery of general achievement tests in seven academic areas: English Expression, Reading, Mechanics of Writing, Mathematics Computation, Mathematics Basic Concepts, Science, and Social Studies. The tests are appropriate for grades 4-14. There are four progressive levels of difficulty for each subject except Mechanics of Writing and Mathematics Computation, which have three levels of difficulty (grades 4-12).

The areas assessed and amount of time for each are: English Expression - 40 minutes, Reading - 45 minutes, Mechanics of Writing - 40 minutes, Mathematics Computation - 40 minutes, Mathematics Basic Concepts - 40 minutes, Science - 60 minutes for levels 1 and 2; 40 minutes levels 3 and 4, Social Studies - 60 minutes for levels 1 and 2; 45 minutes levels 3 and 4.

A, B, C, E

CRATTY EVALUATION OF CHILDREN'S MOVEMENT ABILITIES

A screening test in six categories that can be administered by the teacher. The categories are body perception, balance, locomotion, agility, throwing and catching.

DENVER AUDITORY PHONEME SEQUENCING TEST

This test provides two measures of auditory abilities, single phoneme discrimination and sequenced phoneme memory, for both children and adults. Designed to identify children who will require additional listening training. Easy to administer, requiring no more than 20 minutes. Standardized.

B, D

DENVER DEVELOPMENTAL SCREENING TEST

This test is an individually administered screening instrument primarily intended to aid in the early detection of delayed development in children aged 2 weeks through 6 years and 4 months. The test consists of 105 items arranged in the following four sections: personal-social, fine motor-adaptive, language, and gross motor. The test is relatively simple to administer and interpret. No special training is needed for administration.

A, B, C, D, E, F, G

DETROIT TEST OF LEARNING APTITUDE

The Detroit is an individually administered measure designed to assess strengths and weaknesses in a child's cognitive and linguistic abilities. The tests consist of 19 subtests which assess areas including: reasoning and comprehension, practical judgment, verbal ability, time and space relationships, number ability, auditory attentive ability, and motor ability. It is recommended that a minimum of 9 and a maximum of 13 subtests be administered. Raw scores on each test can be converted to a Mental Age Score. Norms are provided from Mental Ages 3 years, 0 months to 19 years, 0 months.

A, D, E, (B, if specially trained)

DEVELOPMENTAL PROFILE

The Developmental Profile is an inventory of skills which has been designed to assess a child's development from birth to 12 1/2 years of age. The inventory provides a screening of five key areas: physical self-help, social, academics, and communications. The instrument uses an interview format which is either self-administered or informant based. It includes 217 items which are arranged in 6-month intervals from birth to 3 1/2 years and proceeds thereafter by yearly intervals. A short section speaks to the problems of administration to atypical children. These guidelines represent a range of months when behaviors at certain chronological ages are considered either normal or retarded development. Also included is an explanation of the standardization and test development procedures.

B, E

DEVELOPMENTAL RECORD

Information not available at time of printing.

DEVELOPMENTAL TEST OF VISUAL-MOTOR INTEGRATION

This test is designed to assess visual-motor functioning in children from 2 to 15 years of age. The student is asked to reproduce the 24 geometric forms while the form is still present. This test may be used for both screening and appraising specific problems among individual children.

DEVEREUX ADOLESCENT BEHAVIOR RATING SCALE

This is an individual test that takes approximately 15 minutes to administer. The scale is more suitable for very disturbed adolescents.

A, B, C, E

DEVEREUX CHILD BEHAVIOR RATING SCALE

This scale provides an assessment of students 8 through 12 years of age. It is individually administered and takes approximately 10-20 minutes to administer. The test is designed particularly for the emotionally disturbed or mentally retarded.

A, B, C, E

DEVEREUX ELEMENTARY SCHOOL BEHAVIOR RATING SCALE

This is an individual test that takes approximately 10 minutes to administer. The test is conducted by someone who has had at least one month's experience with the child observing the child. The test provides a profile of 11 dimensions of overt problem behavior.

A, B, C, E

DIAGNOSTIC CHART FOR FUNDAMENTAL PROCESSES IN ARITHMETIC

This test is intended to provide information concerning a student's specific errors in arithmetic, subtraction, multiplication, and division of whole numbers. Students complete a graded series of arithmetic examples arranged in order of increasing difficulty in each of the four fundamental processes. The student is asked to work each example aloud, while the administrator notes specific errors. The chart is not standardized, and the results are primarily aimed at helping classroom teachers assess the faulty arithmetic work habits of students in grades two and above. A manual of directions also provides a number of excellent remedial procedures for many arithmetic difficulties.

A, B, C, E

DIAGNOSTIC CHECKLIST FOR BEHAVIOR - DISTURBED CHILDREN (Form E-2)

This questionnaire consists of 80 questions and gathers information about the child's social interaction and affect; speech, motor and manipulative ability; intelligence and reaction to sensory stimuli; family characteristics; illness development; physiological; and other biological data. The information gained from this questionnaire provides much information about the child's development from birth to age five. It is to be filled out by the parents.

DIAGNOSTIC READING SCALES

This is a series of integrated tests designed to provide a standardized, individualized evaluation of skills in oral reading, silent reading and auditory comprehension. The scales consist of three-word recognition lists, 22 reading passages, and eight supplementary phonics tests. The tests can be used with students in elementary grades and older students with reading difficulties.

A, B, C, E

DIAGNOSTIC TESTS AND SELF-HELPS IN ARITHMETIC

Four screening tests quickly assess a student's abilities with whole numbers, common fractions, decimals, and general arithemetic skills. The screening tests show which of the twenty-three analytical tests should be administered. Self-help corrective exercises provide a basis for remediation of any of the specific deficits noted on each of the analytical tests. The test is not standardized. With the test results teachers are able to locate and identify both specific and general areas of difficulty in arithmetic. The results provides an effective basis for planning remedial work.

A, B, C, E

DISTINCTIVE FEATURE ANALYSIS OF MISARTICULATIONS

Text describing the method for analysis of articulation based on distinctive features. Technique involves language sampling, construction of child's phonological rule system, and analysis of errors in terms of distinctive features. This is a time consuming procedure initially, but beneficial in therapy because one may see improvement across a class of sounds with training of an inidividual sound, depending on commonality of features.

D

DURRELL ANALYSIS OF READING DIFFICULTY

This test is designed to be administered individually with students at the nonreading level through sixth grade reading level. The test consists of subtests in: oral and silent reading, listening comprehension, word recognition, and word analysis. Grade level scores are provided for each of the subtests. The test helps the classroom teacher identify specific skill-development strengths and weaknesses in reading.

A, B, C, D, E

EARLY IDENTIFICATION AND TREATMENT OF LEARNING DISABILITIES

Information not available at the time of printing.

ENVIRONMENTAL LANGUAGE INVENTORY (ELI)

The ELI is an individually administered diagnostic strategy for assessment and training of children with severe delay in expressive language. Distribution of semantic-grammatical rules, utterance length, and intelligibility are assessed in three production modes: imitation, conversation, and free play. Traditional normative data are not available for the ELI.

A, B, C, D, E, F

ENVIRONMENTAL PRELANGUAGE BATTERY (EPB)

The EPB assesses preliminary skills up to the use of 2-word phrases.

A, B, C, D, E, F

FISHER-LOGEMANN TEST OF ARTICULATION COMPETENCE

The test is described by a reviewer as a single word articulation profile. It tests all consonants in all positions, consonant blends, and all vowels. Each sound notes developmental age.

Two versions of the Fisher-Logemann Test are available: a Picture Version (109 colorful line drawings on 35 hardboard cards) and a Sentence Version (15 sentences printed in large, legible type on a card). Eleven of the cards in the Picture version are tab-indexed for screening test applications.

Test information yields detailed data re: consonants and vowels. Consonant data includes place of articulation, voicing, and manner of formation. Vowel data includes height of the tongue, placement of the tongue, degree of tension and lip rounding.

The test yields no norms but the extensive test manual (35 pages) yields itself to distinctive feature analysis.

D

FLOWERS AUDITORY TEST OF SELECTIVE ATTENTION

FATSA is a screening tool which measures the auditory attention span for school-age children. Can be administered individually or in groups up to 35 children. Skills are tested by having the child listen to an audiotape and mark one or more of seven pictures provided for each test item. Tables are available indicating selected percentile midyear scores for children in certain categories.

D

FLOWERS-COSTELLO TESTS OF CENTRAL AUDITORY ABILITIES

This test is designed to measure 2 basic areas of auditory perceptual abilities in children from kindergarten through sixth grade. It is divided into 2 subtests of Low Pass Filtered Speech and Competing Message. Each subtest requires the child to correctly interpret a sentence heard by filling in a missing word through picture identification. The test takes approximately 30 minutes to administer and does not require a specialized test environment. Scoring interpretation allows the examiner to assess certain auditory perceptual abilities as well as possibly determining some specific hearing disability.

D and Audiologist

FLUENCY ASSESSMENT BATTERY (FAB)

The FAB is a disgnostic tool developed to measure fluency and rate of speech. Consists of five sections measured by the auditory and visual modalities with the response mode being verbal. Yields a percentage of fluent speech in imitative tasks, nonimitative tasks, reading and conversational speech. Also yields average words spoken per minute. No normative data for interpreting results are provided.

D

FLUHARTY PRESCHOOL SPEECH AND LANGUAGE SCREENING TEST

This screening test is designed to elicit responses from children between the ages of 2 and 6 years which are indicative of vocabulary, articulation, and language performance. Thirty-five test items are divided into the following 3 sections: A-identification of 15 common objects, B-nonverbal responses to 10 sentences incorporating basic syntactic structures, and C-repetition of 10 short sentences stimulated by picture cards. The test is individually administered and requires approximately 6 minutes. Comments on validity and reliability are available in the manual.

D

FROSTIG DEVELOPMENTAL TEST OF VISUAL PERCEPTION

This assessment instrument is designed to measure the following fine visual perceptual skills: eye-motor coordination, figure-ground discrimination, form constancy, position in space, and spatial relationships. The test can be administered to individuals or groups. Students between the ages of 4 and 8 can be administered the test. Raw scores can be converted into scaled scores, perceptual ages, and an overall perceptual quotient.

A, B, C, D, E, G

FULLERTON LANGUAGE TEST FOR ADOLESCENTS (EXPERIMENTAL EDITION)

This test is an individually administered diagnostic assessment of expressive and receptive language. The test consist of 8 subtests: Auditory Synthesis, Morphology Competency, Oral Commands, Convergent Production, Divergent Production, Syllabication, Grammatic Competency, and Idioms. The test is designed for use with adolescents aged 11-18 and adults. Administration and scoring required

approximately 45 minutes.

D

GATES-MCKILLOP READING DIAGNOSTIC TEST

This test includes subtests in oral reading, flashed presentation of words, untimed presentation of words, flash presentation of phrases, knowledge of word parts, recognition of the visual forms of sounds, and auditory blending. It has supplementary tests in spelling, oral vocabulary, syllabification, and auditory discrimination. This test is intended to be used with students in grades 2 through 6 who have severe reading and spelling disabilities.

A, B, C, D, E

GATES-RUSSELL SPELLING DIAGNOSTIC TEST

This test is designed to test the following nine areas: spelling words orally, word pronunciation, giving letters for sounds, spelling one syllable, spelling two syllables, word reversals, spelling attack, auditory discrimination, and the effectiveness of visual, auditory, kinesthetic, and combined methods of study. A grade score can be obtained for each of the subtests. This test can be used as an initial step in observing spelling difficulties.

A, B, C, D, E

GENERAL APTITUDE TEST BATTERY

Developed by the United State Employment Service, this test battery is designed to assess vocationally significant aptitudes useful for vocational counseling, job selection, and job placement. The battery makes predictions for around five hundred occupations, primarily for the unskilled or semi-skilled type and measures aptitudes in 7 areas: general learning ability, verbal aptitude, form perception, clerical perception, motor coordination, finger dexterity, and manual dexterity.

A, C, E with specific training only

GILMORE ORAL READING TEST

This test consists of 10 reading passages that measure accuracy, comprehension, and rate of oral reading. Five comprehension questions to test recall are aked after each reading passage. The test can be used with students in grades 1 through 8.

A, B, C, D, E

GOLDMAN-FRISTOE TEST OF ARTICULATION

The Goldman-Fristoe is a traditional test of articulation designed to evaluate a student's production of consonant sounds. Three subtests are included in the test: sounds-in-words, sounds-in-sentences, and stimulability. It classifies the types and severity of various articulation errors. Norms are provided for children from 3 to 8 years of age.

D

GOLDMAN-FRISTOE-WOODCOCK AUDITORY MEMORY TESTS

This test is individually administered utilizing recorded stimuli to measure short-term auditory memory skills in children and adults. It consists of three separate tests measuring Recognition Memory, Memory for Content, and Memory for Sequence. Raw scores are converted to percentile rank, age equivalent, standard score, and stanine.

D

GOLDMAN-FRISTOE-WOODCOCK AUDITORY SELECTIVE ATTENTION TEST

This test measures an individual's ability to attend to a listening task in the presence of competing noise that is systematically varied in intensity and type. It is composed of 110 items and divided into four subtests. All auditory stimuli are presented by means of prerecorded tape via earphones. Raw score performance may be translated into both age equivalency and percentile rank. Validity and

reliability are questioned pending more research data.

D

GOLDMAN-FRISTOE-WOODCOCK SOUND-SYMBOL TESTS

This is an individually administered test which measures several basic abilities which are prerequisite to advanced language skills. It consists of seven tests to assess the following skills: Sound Mimicry, Sound Recognition, Sound Analysis, Sound Blending, Sound-Symbol Association, Reading of Symbols, and Spelling of Sounds. Normative data are available for the age range of 3 to 80 years, although the major data are for those in the range of 3-12 years.

D

GOLDMAN-FRISTOE-WOODCOCK TEST OF AUDITORY DISCRIMINATION

This test is designed to test auditory discrimination of phonemes against a quiet background and against a noisy background. The examiner uses tape recordings to administer the two subtests. The student views four separate pictures and is asked to select the one that represents the word spoken. The words for each of the four pictures differ slightly. One suggested use of this test is screening of students who are suspected of suffering from serious auditory-perceptual disorders. Yields percentile or standard scores for individuals aged 3 years, 8 months to 70 years and older.

D

GOODENOUGH-HARRIS DRAW-A-MAN TEST

This test may be administered to small groups or for individual students. The test is administered by the examiner instructing the student to make 3 drawings - a man, woman and himself. Specific instructions are given so as to motivate all children similarly. It is suggested for use to determine initial impression of ability and is rated as valuable to obtain a "crude index" of mental development of children for whom no appropriate standardized test of mental ability is available.

A, C, E, G

GRAMMATICAL ANALYSIS OF ELICITED LANGUAGE (GAEL)

This instrument was standardized on over 500 hearing impaired children ages 5-9 years and normally hearing children ages 2 1/2-5 years. Separate normative tables are available for:

Profoundly deaf, 8-12 years
Severely hearing impaired, 8-12 years
Normally hearing, 3-6 years

The GAEL is an assessment technique for eliciting language, evaluating the use of complex sentences.

A, B, C, D, E

GRAY ORAL READING TEST

This test is designed to provide an objective measure of skill development in oral reading from early first grade through college. The test is available in four forms. In administration of the test the student is asked to read the passages aloud while the examiner records errors and notes reading characteristics. The student is then asked a series of questions designed to assess comprehension. The test provides an assessment of both speed and accuracy of oral reading.

A, B, C, E

HAHNEMANN HIGH SCHOOL BEHAVIOR RATING SCALE

Information not available at the time of printing.

HAYES-BINET

Information not available at the time of printing.

HISKEY-NEBRASKA TEST OF LEARNING APTITUDE

Although this test was developed as a non-verbal, non-timed test for the hearing handicapped, norms are also available for children with normal hearing. The following 12 subtests make up the test: bead patterns, memory for color, picture identification, picture association, paper folding, visual attention span, block patterns, completion of drawings, memory for digits, puzzle blocks, picture analogies, and spatial reasoning. For deaf children a Learning Age and a Learning Quotient can be obtained and for hearing children a Mental Age and IQ. While primarily used with deaf children, the test can be used with any child from 3 years to 16 years of age.

A, C, D, E

HOUSTON TEST FOR LANGUAGE DEVELOPMENT

This linguistic assessment of children is divided into two parts. Part I is for very young children, 6 months to 3 years of age, and assesses accent, melody of speech, gesture, vocabulary, sound articulation, dynamic content, and grammatical usage. Part II, which requires the eliciting of free running speech, is used with children from 6 months to 6 years of age. Vocabulary, auditory judgement, syntax, and self-identity are some of the 18 areas assessed in this part of the test. The results of this test are best used to gain an informal estimate of a child's language development, which can be used to plan teaching programs.

D

HUMAN FIGURES DRAWING TEST

Information not available at the time of printing.

ILLINOIS TEST OF PSYCHOLINGUISTIC ABILITIES, REVISED (ITPA)

The ITPA is an individually administered diagnostic test designed to delineate specific abilities and disabilities in children ages 2 to 10 years. The 12 subtests evaluate abilities in channels of communication, psycholinguistic processes, and levels of organization. Results yield a composite psycholinguistic age, an estimated mental age and IQ, and scaled scores on each subtest. Administration time is approximately 60 minutes.

D (A, B, C, E with training)

IOWA INTEREST INVENTORY

These are paper and pencil tests for charting rate of speaking and oral reading, measures of dysfluency, check list of stuttering reactions, scales of severity and attitude regarding stuttering, as well as self-ratings for speech situations and measures of adaptations and of consistency.

D

IOWA PRESSURE ARTICULATION TEST

An individually administered 43-item subtest of the Templin-Darley Tests of Articulation to assess the adequacy of speech sounds requiring greater oral breath pressure and, by inference, the adequacy of palatopharyngeal closure. Selection of items was based on a study of 50 cleft-palate children. Interpretation of scores must be made recognizing that the norms provided are for subjects selected without regard to palatopharyngeal adequacy.

D

IOWA SCALE OF ATTITUDE TOWARD STUTTERING

The Iowa Scale attempts to measure the test taker's reaction to stuttering in social speech situations. The Scale presents 45 assertions about stutterers and what they should or should not do or feel in selected situations. The test taker is asked to indicate by circling a response the extent to which he or she agrees or disagrees with each assertion. Responses are scored in such a way as to indicate appropriateness of attitude toward stuttering.

D

KEY MATH DIAGNOSTIC ARITHMETIC TEST

An individually administered diagnostic test designed to assess math development in kindergarten through the eighth grade. The test includes fourteen subtests organized into three areas: content, operations, and applications. Administration of Key Math is relatively simple, requires no formal training, and takes 20 to 30 minutes to complete. Results include a grade equivalent score based on the total test performance, along with a diagnostic profile depicting performance in the fourteen skill areas. The specific listing of behavioral objectives for every item of the test and the grouping of items into logical instructional clusters facilitate program planning and evaluation.

A, B, C, D, E

KUHN'S SYMPTOM CHECKLIST

Information not available at this time.

KUHLMANN-FINCH SCHOLASTIC APTITUDE TESTS

This is a group administered measure of general mental development. Eight tests are in the battery: one for each grade, grades 1-6; one for junior high; and one for senior high. Both verbal and nonverbal subtests are used to measure intellectual maturity.

A, B, C, D, E

LANGUAGE-STRUCTURED AUDITORY RETENTION SPAN TEST

LARS is an individually administered instrument to assess the ability in individuals, age 3.7 through adult, to maintain short-term memory for linguistically significant information. The examinee may administer the LARS in 12 to 15 minutes by reading the sentences and requiring that the subject repeat them. Yields a mental age and recall quotient.

A, B, C, D, E

LEARNING ACCOMPLISHMENT PROFILE (LAP)

The LAP is a criterion-referenced instrument which has been developed from normative assessment tools as a record of a child's existing skills. The authors claim this assessment's success is based on its ability to test for the criterion within the context of the child's own environment and experiences. With the use of the LAP, the authors feel that the teacher will be able to: identify developmentally appropriate learning objectives; measure progress through change in rate of development; and provide specific information relevant to pupil learning. These tasks are defined for the following skill areas: gross motor, fine motor, self-help, social, cognitive and language.

B, C, E

LEARNING ACCOMPLISHMENT PROFILE FOR INFANTS (LAP-I)

LAP-I is criterion-referenced record for parents and/or teachers of handicapped infant's (0-2) existing skills. This assessment, in combination with the previously developed LAP, provides a full range assessment from 0-5 years of age. The assessment booklet contains two parts. Part One is the actual assessment with a hierarchy of behaviors listed in a developmental sequence in six areas of development: Gross Motor, Fine Motor, Social, Self-help, Cognitive, and Language. Part Two provides units of instruction for teaching important behaviors in the sequence of development such as tracking, attending, self-feeding, etc.

A, B, C, D, F

LEITER INTERNATIONAL PERFORMANCE SCALE

This non-language measure of general intelligence can be used with children ages 2 through 18 years. The scale measures intelligence through matching colors, forms and pictures, copying a block design, picture completion, number estimation, analogies, series completion, spatial relations, similarities, and other such functions.

A, C, E

LINCOLN DIAGNOSTIC SPELLING TEST

This test was designed to measure three facets of spelling: pronunciation, enunciation, and use of rules. Best used as a general measure of spelling performance with analytical features to assess deficiencies in the use of spelling rules.

A, B, C, D, E

LINCOLN-OSERETSKY MOTOR DEVELOPMENT SCALE

This test consists of over 40 individual items and is appropriate for students between the ages of 6 and 14. Examples of skills tapped include motor speed, balance, dynamic coordination, general coordination, overproduction of movements, and jumping.

A, C, E, G

LINDAMOOD AUDITORY CONCEPTUALIZATION TEST

The LAC is an individually administered test which provides a measure of a student's level of auditory functioning in two areas: (1) the ability to discriminate one speech sound from another, and (2) the ability to perceive the number, order, and sameness or difference of speech sounds in sequences. The Lindamood Auditory Conceptualization Test can be used at preschool through adult levels, and no prior knowledge of the alphabet or sound-symbol association is required. The raw score is converted on a simple grid and then compared with grade-level recommended minimum scores.

A, B, C, D, E, G

LING PHONETIC LEVEL SPEECH EVALUATION

This evaluation determines the extent to which particular sound patterns are present, the stage at which the child can differentiate one motor speech pattern from another, and the rate at which sounds can be repeated and alternated. The Cummulative Record of Speech Skill Acquisition and the Teacher Clinician Planbook and Guide to the Development of Speech Skills are useful programming tools available from the same company. This instrument can be administered to infants through adults.

B (Hearing Impaired), D

LOUISVILLE BEHAVIOR CHECKLIST

Information not available at this time.

McCARTHY SCALES OF CHILDREN'S ABILITIES

The MSCA was designed to evaluate children's (ages 2 1/2 to 8 1/2) general intellectual level as well as strengths and weaknesses in a number of ability areas. The test consists of eighteen subtests that make up six scales. Four kinds of scores are obtained: a general cognitive index, scale indexes, percentile ranks, and MA.

The standardization is excellent reflecting normative sample proportions closely approximating the 1970 census data. Reliabilities for the Verbal and General Cognitive scales are excellent; coefficients for the other scales are lower. Evidence about validity is limited although studies of both predictive and concurrent validity are reported. The test does meet the majority of the standards of the American Psychological Association. Specific training qualifies one for administration.

A, C, E

McDONALD DEEP TEST OF ARTICULATION

The MDTA is an individually administered diagnostic instrument designed to assess a student's articulation of phonemes in numerous phonetic contexts. It determines any possible facilitating sounds for error consonants and vowels. Each phoneme the examiner selects is tested and scored individually. A percentage score is completed for each phoneme. May be used with persons from preschool age to adult.

D

MEADOW/KENDALL SOCIAL-EMOTIONAL ASSESSMENT INVENTORY FOR DEAF STUDENTS

This inventory is designed to be completed by teachers or other educational personnel with close contact with deaf students aged 7 to 21 years of age. The inventory contains 3 subscales: Social Adjustment, Self-Image, and Emotional Adjustment.

A, B, C, E

MEETING STREET SCHOOL SCREENING TEST (MSSST)

The MSSST is a screening device designed to assist in early identification of children with learning disabilities. Utilization of this test provides a determination of how effectively a child is processing information through 3 subtest modalities: Motor Patterning, Visual-Perceptual-Motor, and Language. Yields raw scores, scaled scores, and behavior ratings. Norms are available that span the age range 5.0 to 7.5 years. The MSSST is individually administered in 15-20 minutes.

A, B, C, D, E, G

MERRILL-PALMER TESTS OF MENTAL ABILITIES

The tests assess not only the child's cognitive abilities but fine and gross motor skills in a very general manner. Comprised primarily of performance items, some of which are timed, this tool is very useful with nonverbal children. Provision is made for a child's refusal of an item or for a necessary omission of an item.

A, C, E

MILANTI-COMPARETTI SCALES OF MOTOR DEVELOPMENT

Information not available at time of printing.

MINNESOTA PRESCHOOL SCALE

The test consists of a series of twenty-six short subtests that provide an estimate of verbal and nonverbal intelligence. The test is designed for children ages 1 year, 6 months to 6 years and can be administered in thirty minutes or less on an individual basis.

A, C, E

MINNESOTA TEST FOR DIFFERENTIAL DIAGNOSIS OF APHASIA

The MTDDA is an individually administered tool designed to differentiate specific subgroups within the generic category of aphasia. Consists of 57 subtests composed of varying numbers of items. The subtests are categorized into five groups representing primary areas of language/symbolic disturbance (auditory, visual and reading, speech and language, visuomotor and writing disturbances, and disturbances of numerical relations and arithmetic processes). Results may be reported as numerical indices of severity of impairment.

D

MODERN TECHNIQUES OF VOCAL REHABILITATION

This reference text contains information on the clinical diagnosis and treatment of vocal disorders.

D

MOTOR-FREE TEST OF VISUAL PERCEPTION

This test does not require any fine motor skills as the student is asked to point to one of four alternatives. The test is divided into the following five subtests: spatial relationships, visual discrimination, figure-ground, visual closure, and visual memory. The test can be administered in approximately 10 minutes and yields a perceptual age and a perceptual quotient.

A, B, C, E

MOTOR SPEECH DISORDERS

This reference text includes chapters containing specific clinical tasks for the differential diagnosis and treatment of motor speech disorders, particularly the dysarthrias and apraxia of speech.

D

NORTHWESTERN SYNTAX SCREENING TEST

This is an individually administered screening test designed to estimate a student's receptive and expressive levels of syntatic development. Normative data are provided for children 3 years, 11 months to 7 years, 11 months of age. Receptive development is measured by having the child select the most appropriate of four pictures following a sentence spoken by the administrator. The expressive items require the child to repeat sentences spoken by the administrator while the administrator points to various pictures. The child derives meaning from word order and word endings.

D

OHIO TESTS OF ARTICULATION AND PRECEPTION OF SOUNDS

The OTAPS is a basic battery of eight subtests designed to evaluate children's articulation and perception of speech sounds. This test is appropriate for children from ages approximately 5-8 (K-3rd grds). Detailed standardization procedures, validity and reliability information is contained in the Manual.

D

ORDINAL SCALES OF PSYCHOLOGICAL DEVELOPMENT

Series of six ordinal scales based on Piagetian observations of sensory-motor schemas. Concerned with the hierarchial interrelationship of achievement at different levels. Six scales include visual pursuit and the permanence of objects, the development of means for obtaining desired environmental events, development of operational casuality, construction of objects in space, and verbal and gestural imitation. Also assessed is the development of schemas for relating to objects.

A, C, D, E

OSTERETSKY TEST OF MOTOR PROFICIENCY

This individually administered test includes items that assess both fine and gross motor control. The specific subtests include: running speed and agility, balance, bilateral coordination, strength, upper-limb co-ordination, response speed, visual-motor control, and upper-limb speed and dexterity. Children ages 4 to 18 can be administered the test.

A, C, E, G

PARENTAL DIAGNOSTIC QUESTIONNAIRE

The PDQ is a clinical tool designed for evaluation, prevention, and treatment of stuttering in children. It is designed to be completed by parents, guardians, or others who may be significant in the child's communicative environment. It provides a broad profile of parental/adult attitudes, observations and reactions to dysfluent speech which can serve as a basis for parent/teacher counseling.

D

PATTERSON'S PROBLEM CHECKLIST

Information not available at this time.

PEABODY DEVELOPMENTAL MOTOR SCALES

The motor scales were designed as a measure of the skills a child has mastered, those he is developing, and those not yet learned in the areas of fine and gross motor skills. The scales are being issued only in an experimental edition with validation efforts currently in process. The scale use a rating system from "1" to "5" with definitive accompanying criterion. Included in the monograph

is a program of activities designed to teach each skill in the scales. The authors assume the activities will lead to a program that attempts to fill developmental gaps, to strengthen emerging skills and to set objectives for skills not obtained.

B, C

PEABODY INDIVIDUAL ACHIEVEMENT TEST

This test is designed to survey a student's level of educational attainment in basic skills and knowledge. The five subtests include: mathematics, reading recognition, reading comprehension, spelling, and general information. The test measures achievement from preschool to adult level.

A, B, C, D, E

PEABODY PICTURE VOCABULARY TEST - REVISED (PPVT-R)

The PPVT-R is an individually administered screening tool which provides a measure of single-word receptive vocabulary. To administer the scale, the examiner shows a plate and says the corresponding stimulus word. The subject is required to point to, or otherwise indicate, the picture which best illustrates the meaning of the stimulus word. The PPVT-R is available in parallel forms, L and M, and consists of a series of 175 plates graduated in difficulty. The PPVT-R can be administered and scored in 10 to 20 minutes and can be used with persons 2 1/2 through 40 years of age. This test offers norms based on a thorough national standardization, including adult norms.

A, B, C, D, E

PETERSON-QUAY RATING SCALE

Information not available at this time.

PHOTO ARTICULATION TEST

The PAT is an individually administered screening instrument designed to rapidly assess the articulatory skills of children ages 3 to 12 years. Twenty-three consonants are tested in initial, medial, and final positions. Eighteen vowels also are tested. It consists of 72 color photographs of objects which the child is required to name. Yields a total score and subscores which are calculated for tongue sounds, lip sounds and vowel sounds, for comparison with the normative sample.

D

PICTURE STORY LANGUAGE TEST (WRITTEN LANGUAGE)

The Picture Story Language Test is a diagnostic instrument for normal and handicapped children with language disorders and other types of learning disabilities. It can be administered individually or in groups, as subjects are required to write a story based upon a standard picture card stimulus. The test is comprised of three scales, one devised to measure length (Productivity), another to measure correctness (Syntax), and the third to measure content or meaning (Abstract-Concrete). Standardized on 747 subjects ranging in age from 7 to 17 years.

D

PORCH INDEX OF COMMUNICATIVE ABILITY IN CHILDREN (PICAC)

The PICAC is an individually administered diagnostic battery which measures multidimensions of communicative behavior. The Basic Battery (16 tests) is designed for children 3 to 6 years old; the Advanced Battery (20 tests) is for children 6 to 12. The Subtests are structured around 10 objects requiring talking, handling objects, or drawing. Employs very sophisticated statistical methods to insure high reliability and clinical usefulness. Administration requres usually 30 to 60 minutes.

D, with training and extensive practice

PREDICTIVE SCREENING TEST OF ARTICULATION

The PSTA is an individually administered screening test for children at the 1st grade level to separate those children who will master their misarticulations without speech therapy from those who will require intervention. Consists of 47 items of imitative tasks. Results are interpreted in terms

of normative data indicating percentage of children who acquired normal articulation by 3rd grade without therapy with particular PSTA Score.

D

PRESCHOOL BEHAVIOR QUESTIONNAIRE

Information not available at this time.

PRESCHOOL LANGUAGE SCALE-REVISED

The Preschool Language Scale consists of a series of auditory and verbal language tasks designed for children aged 18 mo. to 7 years. This screening device provides a detailed survey of a child's early language comprehension. It can be used in approximately 20 minutes. Yields language ages and language quotient. Details of validity and reliability studies are available in the program manual.

A, B, C, D, E

PROCEDURES FOR THE PHONOLOGICAL ANALYSIS OF CHILDREN'S LANGUAGE

Text by Ingram called Phonological Disability in Children describes assessment, analysis and treatment of language disabilities. Provides procedures for collection of speech samples, analysis of speech into phonological rules, and determination of a program of therapy. Also provides overview of normal phonological development and an examination of how deviant speech differs from the normal patterns.

D

PROGRAMMED THERAPY FOR STUTTERING IN CHILDREN AND ADULTS

This text covers behavioral principles as related to stuttering, evaluation, and programming. It includes two forms of a Stuttering Interview as an assessment tool. Form A is designed for preschool and primary children while Form B is for upper elementary, junior high, senior high and adults.

D

PSYCHOEDUCATIONAL PROFILE (PEP)

The PEP is an inventory of behaviors and skills designed to identify uneven and idiosyncratic learning patterns. It is most appropriately used with children functioning at a preschool age level within the chronological age range of one to 12 years. As an assessment instrument, the PEP provides information on developmental functioning in the areas of Imitiation, Perception, Fine Motor, Gross Motor, Eye-Hand Integration, Cognitive Performance, and Cognitive Verbal skills. As a diagnostic too, the PEP identifies the degrees of behavioral pathology or psychosis in the areas of affect; relating, cooperating, human interest; play and interest in materials; sensory modes; and language.

PUPIL BEHAVIOR INVENTORY

Information not available at the time of printing.

PUPIL RATING SCALE

This rating scale consists of the following five behavioral subtests: auditory comprehension, spoken language, orientation, behavior, and motor skills. Each category includes several specific items and the classroom teacher rates the student from 1 to 5 on each item.

A, B, C, D, E,

PURDUE PERCEPTUAL-MOTOR SURVEY

This survey of motor behavior provides for observation of motor skills of a student. This survey provides an opportunity to observe the following: balance and posture, body image and differentiation, perceptual-motor match, ocular control, and form perceptions. In total, 22 scores or ratings are taken. The normative data provided in the survey manual permits a determination of the most crucial areas of faulty performance.

A, B, C, E, G

READING COMPREHENSION BATTERY FOR APHASIA (RCBA)

The RCBA is an individually administered instrument designed to evaluate the nature and degree of reading impairment in aphasic adolescents and adults (anyone who has achieved a 6th grade reading level). Administration requires 30 to 90 minutes for 10 subtests: six pertaining to Single word comprehension, one for Sentence Comprehension, and two for Paragraphs. Each subtest consists of 10 items.

D

READING-FREE VOCATIONAL INTEREST INVENTORY

The purpose of the test is to assess an individual's preference for particular work areas. In administration of the test, an individual is presented with three pictures and asked to select one. To determine each individual's preference for each interest area, the number of times he/she select items that are keyed for that area are totaled and converted to percentile ranks. The percentiles allow for direct measurement and interpretation of each subject's vocational likes and dislikes.

A, B, C, D, E

RECEPTIVE-EXPRESSIVE EMERGENT LANGUAGE SCALE (REEL)

The REEL is a method of examining a child's language functions through interviewing the parents. The items are scaled over the age range from birth to three years.

A, B, C, D, E, G

ROUGHNESS DISCRIMINATION TEST

Information not available at the time of printing.

SCHOOL AND COLLEGE ABILITY TEST (SCAT)

SCAT Series II, a complete revision of the original SCAT tests, was normed in 1966 and renormed in 1970. Tests in SCAT Series II have only two parts: Verbal and Quantitative. Part I (Verbal) measures a student's understanding of words with verbal analogy items. Part II (Quantitative) tests a student's understanding of fundamental number operations by quantitative comparison items. These new items require the student to compare the magnitude of two mathematical quantities and make certain decisions concerning them.

The test yields three scores: Verbal, Quantitative, and Total. Total working time is 40 minutes: 20 minutes for each part. SCAT Series II included tests at four levels of difficulty. Parallel forms which are comparable in content coverage and difficulty are available at each level.

A, B, C, D, E

SCREENING DEEP TEST OF ARTICULATION

The SDTA is an individually administered instrument designed to screen a student's articulation of several commonly misarticulated consonants as they appear in a variety of phonetic contexts. Based on theory that consonants function to either release or arrest a syllable. Yields a graphic phonetic profile based on percentage of correct production for each sound.
Age: Preschool to adult

D

SCREENING TEST FOR AUDITORY COMPREHENSION OF LANGUAGE

The STACL is a screening test which identifies children between 3 and 6 years of age who may have receptive language problems. The group-administered test consists of 25 items from the TACL which sample vocabulary, morphology, and syntax. The children are required to respond to the examiner's oral stimuli by marking in individual booklets. Reliability data and cut off tables are provided in the manual.

A, B, C, D, E

SCREENING TEST FOR DEVELOPMENTAL APRAXIA OF SPEECH

This is an individually administered screening instrument designed to assist in the differential diagnosis of developmental apraxia of speech in children ranging from 4-12 years. Consists of eight (8) subtests including: Expressive Language Discrepancy, Vowels and Diphthongs, Oral-Motor Movement, Verbal Sequencing, Motorically Complex Words, Articulation, Transpositions, and Prosody. Administration requires approximately 10 minutes.

D

SCREENING TEST OF ADOLESCENT LANGUAGE (STAL)

The STAL was designed as an individually administered screening instrument for use with junior and senior high school students. The test includes 23 items divided among 4 subtests as follows: 1) Vocabulary-comprehension of word meaning and substitution of a synonym in a grammatically correct form; 2) Auditory Memory Span-repetition of a sentence in its original syntatical form; 3) Language processing-understanding of sentences and isolation of the absurdity contained therein; and 4) Proverb Explanation-comprehension and interpretation of proverbs. Norms provided for use with students 11 years and older. A discussion of the validity and reliability of the STAL can be found in the manual.

A, B, C, D, E

SELF-DIRECTED SEARCH (SDS)

The SDS is a self-administered, self-scored, and self-interpreted vocational counseling. It includes an assessment booklet and occupational classification booklet. The Form Easy (E) was developed for adolescents and adults with limited reading skills. Percentile score tables are available for high school and college levels.

A, B, C, D, E, G

SKI-HI LANGUAGE DEVELOPMENT SCALE

A parent observation scale listing the receptive and expressive language skills of children ages birth to five. Specifically designed for hearing impaired children.

A, B, C, D, E, G

SKI-HI RECEPTIVE LANGUAGE TEST

A picture test which evaluates the young child's receptive understanding of one-, two-, three-, and four- element utterences using a core vocabulary of 100 words.

A, B, C, D, E, G

SLINGERLAND SCREENING TESTS FOR IDENTIFYING CHILDREN WITH SPECIFIC LANGUAGE DISABILITIES

The purpose of this test is to screen young children for potential language impairments that relate to reading, writing, spelling, and speaking. Nine subtests are used to measure such variables as visual copying, visual memory, visual discrimination, auditory memory, auditory perception, and auditory-visual association. Additional tests which can be administered include: oral sentence completion, retelling a brief story, and word repetition.

A, B, C, D, E

SLOSSON INTELLIGENCE TEST

This individual test of intelligence requires approximately 15 to 20 minutes to administer. The test correlates well with the Wechsler tests and the Stanford-Binet. Although the test is applicable from 15 days to 27 years, all testing above age 4 is verbal in presentation and requires spoken responses. With minimal training, this test can be given by the classroom teacher to provide a quick estimate of mental ability.

A, B, C, E

SOCIAL AND PREVOCATIONAL INFORMATION BATTERY

The SPIB consists of a series of nine tests designed to assess knowledge of skills and competencies widely regarded as important for the ultimate community adjustment of educable mentally retarded students in junior and senior high schools.

SPIB tests are orally administered. The response format is true-false or picture selection so that students are not penalized for reading deficiencies. There is one format and one level comprising 227 items. It usually takes 15-25 minutes for each of the nine tests.

The SPIB was developed and researched at the Rehabilitation Research and Training Center in Mental Retardation at the University of Oregon.

SOCIAL AND PREVOCATIONAL INFORMATION BATTERY, FORM T

The SPIB-T edition is designed especially for use with mildly to moderately retarded (TMR) students. Changes were made in the administration directions, item response formats, and word difficulty in the original.

SOUTHERN CALIFORNIA FIGURE-GROUND PERCEPTION TEST

This test assesses figure-ground perception in children and adults. The test is comprised of pairs of achromatic plates, nine of which use overlapping outlines of common objects and nine of which use embedded geometric figures. The test can be administered with students ages 4 through 10 and may be administered in approximately 20 minutes.

A, C, E

SPELLMASTER: SPELLING, TESTING, AND EVALUATION

This is a diagnostic spelling test which measures the following three categories of words: regular words with uniform phoneme-grapheme correspondences, irregular words which do not follow basic phonological and morphological rules, and homonyms which must be learned in conjunction with their meaning. A scope-and-sequence chart that contains all the regular phonic and structural elements tested is included. By using this chart an initial level for diagnostic testing can be selected. Other parts of the program include student-response sheets, class-data charts for profiling the performance of an entire class, and individual progress records for specific students.

A, B, C, D, E

SRA ACHIEVEMENT SCALES

Information not available at the time of printing.

SRA PRIMARY MENTAL ABILITIES TEST

This test indicates grade placement for ability grouping. Areas tested include: verbal meaning, perceptual speed, spatial ability, reasoning, and number sense. The primary battery requires no reading.

A, C, E

STANFORD ACHIEVEMENT TEST

This achievement test is designed to assess skill development in the following academic areas: vocabulary, reading comprehension, word study skills, mathematics concepts, mathematics computation, mathematics applications, spelling, language, social science, science, and listening comprehension. Three forms of the test are available at six levels from grades 1.5 to 9.5. The description of item-by-item behavior samplings and provision of specific instructional objectives make it useful to the classroom teacher. There are two special editions for assessing the blind or partially sighted and one for the deaf.

A, B, C, D, E

STANFORD ACHIEVEMENT TEST

The individually administered SAT is both a norm-referenced and "objective referenced" test designed to assist skill development in several academic content areas. Three forms of the test, A, B, C, are available at six levels from grades 1.5 to 9.5.

Standardization is outstanding. Reliabilities range from .65 to .97 with the majority between .85 and .95. Content validity is adequate.

A variety of transformed scores are obtained: stanines, grade equivalent scores, percentiles, age scores, and various standard scores.

A, B, C, D, E

STANFORD-BINET INTELLIGENCE SCALE

An individual measure of intelligence which yields an IQ. The test ranges in difficulty from the 2-year level to the superior-adult level. In general, this test stresses verbal skills. Only individuals who have received specific training are qualified to administer this test.

A, C, E

STANFORD DIAGNOSTIC MATHEMATICS TEST

This is a group-administered test designed to be both norm-referenced and criterion-referenced. The test measures competence in the basic mathematical concepts and skills that are important in daily affairs and prerequisite to the continued study of mathematics. The primary purpose of the test is to identify specific areas in which a student is having difficulty. Each of four levels consists of three subtests: number system and numeration, computation, and application.

A, B, C, D, E

STANFORD FUNCTION DEVELOPMENTAL ASSESSMENT

This very detailed sequential scale offers behavioral tasks for evaluating both fine and gross motor skills. Gross motor skills include strength and coordination, locomotion, balance, eye-foot coordination, and visual motor-upper limbs. Fine motor skills include reach, carry, and bilateral coordination, prehension, thumb-finger manipulation, grasp, placement, release, and eye-hand coordination, and graphics.

B, G

STANFORD TEST OF ACADEMIC SKILLS

This test is an upward extension of the SAT. It is used to assess the preparation of high school students in the basic skill areas of reading, English, and math. A total of approximately 120 minutes are required for administration.

A, B, C, D, E

STRUCTURED PHOTOGRAPHIC LANGUAGE TEST

The purpose of the SPLT is to evaluate a sample of a child's expression of various syntactical structures and forms under controlled conditions. This test measures the 4-0 to 8-11 year old child's generation of specific structures, using controlled visual and auditory stimuli. Each structure is elicited by an introductory statement and photograph. Responses to be generated by the subject are in the form of sentences. The sentences generated include affirmatives, negatives, imperatives, "wh" questions, and interrogative reversals.

D

STUTTERING SEVERITY INSTRUMENT

This is an individually administered instrument used for school age children and adults. It can be used with readers and nonreaders. The instrument meets the criteria of simplicity, objectivity, and sensitivity to fluency changes. The SSI measures severity in three parameters: frequency of repetition and prolongation of sounds and syllables, and observable physical concomitants.

Reliability and validity have been established. Administration yields a numerical score from 0-45 which provides an assessment of severity and a reference point for measuring clinical changes.

D

STUTTERING THEORY AND TREATMENT

This reference text covers evaluation and treatment of stuttering. It is divided into four parts: Basic Considerations, Mitigation of Stuttering, Therapy, and Management. The Management section is broken into Assessment (including appraisal, description of present stuttering, relevant history, experience and reaction) and Therapy and Counseling.

D

STUTTERING: THERAPY FOR CHILDREN

This text covers introduction to, diagnosis of, and therapy with the person who stutters. Therapeutics is divided according to stage: incipient, transitional, confirmed, and advanced. Provided in the appendix is a four-page checklist for use in diagnosis and evaluation, which focuses on overt speech patterns. Computes duration of repetitions of words, syllables, sounds, and hard contacts or prolongations.

D

TEMPLIN-DARLEY TESTS OF ARTICULATION

While this is a diagnostic test, 50 designated items can be used for screening purposes. The test taps a child's ability to produce vowels, diphthongs, single consonants, and consonant blends. During the test a child is required to say a series of single words that contain a test sound or a combination of sounds in a specific position. When these are not articulated properly, the child is given a correct pronunciation of the word and asked to repeat it. The degree of a child's intelligibility can be evaluated.

D

TEST OF AUDITORY COMPREHENSION

The TAC begins with simple auditory discrimination tasks and proceeds through ten subtests to a measure of the child's understanding of complex stories given with competing message background. Administration averages about thirty minutes. The TAC was standardized on a national sample of 750 pupils, four to twelve years old, with moderate through profound hearing losses. Tests results produce a profile of the child's performance on a continuum of auditory abilities, providing a basis for placement on the Auditory Skills Curriculum available from the same company.

A, B, C, D, E

TEST OF AUDITORY COMPREHENSION OF LANGUAGE (TACL)

The TACL is an individually administered test designed to measure receptive language in children from 3 to 6 years of age. The test includes 101 items which assess a child's receptive proficiency in vocabulary, morphology, and syntax. The child is required to respond to pictorial stimuli. No verbal response is required. The test manual contains data on reliability and validity.

D

TEST OF ADOLESCENT LANGUAGE (TOAL)

The TOAL is an individually administered multidimensional device for assessing language abilities of students in grades 7-12. It can be used to: (1) identify problems in spoken and written language, (2) specify areas in need of intervention, and (3) conduct research. Eight subtests provide information about vocabulary (Semantics) and Grammar (Syntax) in the areas of Listening, Speaking, Reading, and Writing. Normative information is available for students aged 11-0 through 18-5, grade 7 to 12.

D

TEST OF CONCEPT UTILIZATION (TCU)

The TCU is an individually administered clinical instrument which provides qualitative and quantitative assessment of the use of verbally expressed concepts and a classification of responses into a wide range of category detail. Subject is presented 50 pairs of colored pictures of common objects and must indicate verbally how they are alike or go together. Standardized on over 700 subjects from ages 4 1/2 - 18 1/2 years.

D

TEST OF LANGUAGE DEVELOPMENT

This highly standardized individually administered test is used with children ranging in age from 4 years to 8 years, 11 months of age. The seven subtests measure selected aspects of semantics (Oral Vocabulary and Picture Vocabulary), syntax (Grammatic Understanding, Sentence Imitation and Grammatic Completion) and phonology (Word Articulation and Word Discrimination). A child's performance will reveal intra-individual strengths and weaknesses. The test can be administered in approximately 40 minutes.

D

TEST OF NONVERBAL AUDITORY DISCRIMINATION

TENVAD is a fully-recorded test designed to identify primary-grade children who have auditory discrimination problems which may affect later academic success. Contains five subtests to assess discrimination of pitch, loudness, rhythm, duration, and timbre. Can be group administered and requires no special training.

A, B, C, D, E

TEST OF SYNTACTIC ABILITIES

The screening test describes a general profile of strengths and deficiencies in nine basic syntactic structures: negation, conjunction, determiners, question formation, verb processes, pronominalization, relativization, complementation, and nominalization. The diagnostic battery is an individually administered test consisting of twenty subtests that specifically evaluate each structure. This test is nationally standardized for prelingually, profoundly deaf from 10 through 18 years of age.

A, B, C, D, E

TEST OF WRITTEN LANGUAGE (TOWL)

The TOWL is used to identify students with difficulty in written expression, pinpoint specific areas of deficit, and conduct research. Yields information on seven areas of writing competence, including: (1) Word Usuage (verb tenses, plurals, pronouns); (2) Style (punctuation and capitalization); (3) Spelling; (4) Thematic Maturity (construction of meaningful story); (5) vocabulary; (6) Thought Units (# complete sentences); (7) Handwriting. Normative data are available for each six month age interval between 7-0 and 14-6.

A, B, C, D, E

TEST OF WRITTEN SPELLING

This test is designed to pinpoint a student's current spelling level as well as specify the basic types of words with which the student is having difficulty. The test is administered by dictating a list of predictable and a list of unpredictable words. Raw scores are translated into a spelling age score, a spelling quotient, and a spelling grade equivalent. The test can be administered individually or to a small group of children.

A, B, C, D, E

THE BOONE VOICE PROGRAM FOR CHILDREN

This program has been designed to provide guidelines and materials for diagnosis and remediation of voice disorders in children ranging from K through grade 6. The Boone program is administered individually and consists of the following major components: Screening, Evaluation and Referral

Manual, and Remediation Manual.

D

THE DISFLUENT CHILD: A MANAGEMENT PROGRAM

This reference text covers evaluation and treatment of stuttering in children. It is a good reference for developing a program for counseling parents on how to modify the environment to remove stress. Expecially good for use with borderline cases where the child may be developing stuttering behaviors.

D

THE FLETCHER TIME BY COUNT TEST OF DIADOCHOKINETIC SYLLABLE RATE

This test was designed as a method for recording diadochokinetic syllable rate and comparing results to norms by age for 6 years through 13 years. Scores are recorded which represent the time consumed in 20, 15 and 10 repetitions of the syllables and syllable combinations listed on the chart. These scores are compared to a set of standardized norms.

D.

THE GEIST PICTURE INVENTORY: MALE AND FEMALE

This instrument in most cases can be self-administered. It assesses quantitatively eleven male and twelve female general-interest areas and identifies motivating force behind occupational choice. A useful interest inventory in working with those having limited verbal ability is provided. Norms are available for grades 8 through 12, Junior College, University, Trade School and various occupational groups.

A, B, C, D, E, G

THE STOCKER PROBE TECHNIQUE

The Stocker Probe Technique is an approach to the evaluation and treatment of stuttering in children. Designed to evaluate severity and differentiate as early as possible the confirmed stutterer from the child who demonstrates normal dysfluency, and to provide an ongoing measure of dysfluency from week to week. Technique includes phases of: Initial interview, Establishing baseline, Treatment, On-going evaluation, and Re-evaluation.

D

THE TEACHING RESEARCH MOTOR-DEVELOPMENT SCALE

Development of these scales are based on the need for a motor proficiency scale which was developmentally lower than existing motor scales. The scales are not to measure general intelligence, but rather motor proficiency. The kit includes needed equipment; number of trials; directions; scoring criteria; and points earned. The scale covers 51 different items related to such areas as standing, touching, stepping, ducking, tracing, cutting, pushups, running and more. A complete materials list is included along with a recommended recording form.

B, G

THE TESTING-TEACHING MODULE OF AUDITORY DISCRIMINATION

The TTMAD is divided into 2 portions: a test of auditory discrimination (TAD) and a series of games and activities for training. TAD is individually administered and tests 6 areas: initial and final consonants, initial and final blends and digraphs, and vowels and vowel combinations. Scores are interpreted by percentage correct, 80% indicates mastery. The TAD is criterion referenced, so no normative data were gathered.

A, B, C, D, E

THE TOKEN TEST FOR CHILDREN

The Token Test for Children is an individually administered screening tool designed as a rapid and effective measure for assessing subtle receptive language dysfunction in children. The test is

divided into five parts, each presenting progressively longer and more complex commands, for a total of 61 items.

Responses are scored as correct or incorrect based on manipulation of tokens (large and small circles and squares of varying colors). No verbal responses are necessary: The Token Test for Children can be administered to children between the ages of 4 and 12 and takes approximately 8 minutes.

A, C, D, E

THE TREE/BEE TEST OF AUDITORY DISCRIMINATION

This test surveys auditory discrimination abilities in individuals or small groups between the ages of 3 and 9 (normed), through adults (not normed). Covers a wide range of tasks: discrimination of words, phrases, words-in-story comprehension, word pairs, same-different comparisions, pointing to words, and letter discrimination. Information on validity and reliability is provided in manual.

A, B, C, D, E

UTAH TEST OF LANGUAGE DEVELOPMENT

This test is designed to screen expressive and receptive verbal language skills in children from 1 to 15 years of age. General categories of language measured by the test include: repetition of digits, naming of colors, naming of pictures, copying designs, length of sentences, vocabulary, responding to simple demands, and reading. Results serve as a useful checklist of normal language development. The test can be administered in approximately 45 minutes and is probably best used as an estimate of a child's language development.

D

VINELAND SOCIAL MATURITY SCALE

This scale evaluates the degree or level of social competence through the measurement of personal social maturation. The scale establishes a hierarchy of performances which represent an index of capacity to take care of oneself and to participate in the adult activities of society. The 117 items on the scale are divided into sections on self-help (general), self-help (eating), self-help (dressing), locomotion, occupation, communication, self-direction, and socialization. The scale has provisions for social values up to age 30.

A, B, C, D, E, F

THE VOICE AND VOICE THERAPY

Information is not available at this time.

D

THE WORD TEST

This test was designed to probe a child's abilities in understanding and using his vocabulary/semantic systems. Selected testing areas include: Associations, Synonyms, Semantic Absurdities, Antonyms, Definitions, and Multiple Definitions. Designed for use with the language-disordered child above age seven. Available information states that normative data is now being gathered.

D

TOTAL COMMUNICATION RECEPTIVE VOCABULARY TEST

This is a diagnostic instrument to measure receptive vocabulary acquisition in deaf and hard-of-hearing children ages 3-12 who use total communication. Norms are available on deaf, hard-of-hearing, and hearing children.

A, B, C, D, E (Trained in sign language)

UNIFORM PERFORMANCE ASSESSMENT SYSTEM

Information not available at time of printing.

VERBAL LANGUAGE DEVELOPMENT SCALE

This scale is an indirect assessment of verbal language skills and is an extension of the communication portion of the Vineland Social Maturity Scale. Useful for preschool and school-aged children. Administered through interview with someone who knows the subject well.

A, B, C, D, E, G

VISUAL AURAL DIGIT SPAN TEST

The VADS Test is an individually administered instrument which provides a standardized measure of short-term memory. Designed as a diagnostic tool in assessing memory, recall, and sensory integration in children 5.5 to 12 years of age. It consists of four subtests, each of which requires the child to reproduce a series of two-digit to seven-digit numbers under different conditions. Easily administered and can be quickly scored and interpreted by use of well-researched normative data.

D

VISUAL EFFICIENCY SCALE

Information not available at the time of printing.

VOCABULARY COMPREHENSION SCALE

The Vocabulary Comprehension Scale provides information about a child's comprehension of pronouns and words of position, quality, quantity, and size. Four game-style activities make up the Scale: Garage, Tea Party, Buttons, and Miscellaneous. Brightly illustrated materials and objects are manipulated by the child in response to the examiner's spoken directions. This Scale is individually administered and is appropriate for children between the ages of 2 and 6. Administration time is 20 minutes. Standardization and normative data gathered from a culturally diverse, middle-income population in a metropolitan area at Texas are provided in the manual. Requires no verbalization on the part of the child.

B, D

VOCATIONAL INTERESTS AND SOPHISTICATION

Information not available at this time.

VOICE PROBLEMS OF CHILDREN

This reference text contains specifics of assessment and treatment for voice disorders in children. It consists of twelve chapters, covering description, causes, assessment, therapy and habituation/dismissal. Assessment is divided into two sections: Examination I - Voice Team, Head and Neck, Case History; Examination II - Examinations by the Speech Pathologist.

D

WALKER PROBLEM BEHAVIOR IDENTIFICATION CHECKLIST

This checklist is used with elementary children with behavior problems. The rating scale can be administered by anyone familiar with the child and can be administered in several minutes. The checklist consists of five scales: Acting-out, Withdrawal, Distractibility, Disturbed Peer Relations, and Immaturity. The scale is normed for grades 4, 5, and 6.

A, B, C, D, E, F, G

WASHINGTON SPEECH SOUND DISCRIMINATION TEST

The WSSD Test is composed of five subtests, for a total of 53 test items. It is administered individually and permits the quick evaluation of speech sound discrimination ability of children ranging in age from three to kindergarten age. This test does not require a verbal response, nor is the child required to make a same-different discrimination. A scoring table is available by which an age level of functioning to the nearest half year can be reported.

D

WECHSLER ADULT INTELLIGENCE SCALE

This individual intelligence test measures primarily the same behavior as the other Wechsler scales. The major difference in this scale is for those over 16 years of age and older. This test can be administered only by individuals who have received specific training.

A, C, E

WECHSLER INTELLIGENCE SCALE FOR CHILDREN

This standardized intelligence test gives separate IQ scores for a verbal scale, performance scale, and total scale. The test can be used with children age 6 through 16. Only individuals who have received specific training are qualified to administer this test.

A, C, E

WECHSLER INTELLIGENCE SCALE FOR CHILDREN-REVISED

In its revised edition this standardized intelligence test gives separate IQ scores for a verbal scale, performance scale, and total scale. The verbal scale includes six subtests: information, comprehension, arithmetic, similarities, vocabulary, and digit span. The performance scale also includes six subtests: picture completion, picture arrangement, block design, coding, object assembly, and mazes. The test can be used with children from age 6 through 16. This test can be administered only by individuals who have received specific training.

A, C, E

WEISS COMPREHENSIVE ARTICULATION TEST

The WCAT is an individually administered tool to assess articulatory patterns of persons from preschool-age up. Available in 2 forms: pictures and sentences. Samples consonants, vowels, diphthongs, and consonant blends. Yields an articulation score and age, intelligibility score, auditory-visual stimulability score, and number of misarticulations. Data on validity and reliability are available.

D

WIDE RANGE ACHIEVEMENT TEST

Achievement test designed for ages 5 years to 64 years. Consists of reading test (recognizing and naming letters, pronounding words out of context), spelling test (copying marks resembling letters, writing name, writing words to dictation), and arithmetic (counting, reading number symbols, solving oral problems, and written computations). Yields grade equivalent standard score, and percentile rank. The arithmetic subtest is relatively good for use with the hearing impaired because, except for early level skills, the need for verbal directions is minimal.

A, B, C, E

WIDE RANGE INTEREST-OPINION TEST (WRIOT)

The WRIOT consists of 450 pictures arranged in 150 combinations of three which may be administered in groups or individually. The WRIOT pictures are useful in the study of persons of good ability, but limited schooling and inferior reading ability. Norms are available for males and females ages 5 to 35 and up.

A, B, C, D, E, F, G

WILLEFORD BATTERY OF CENTRAL AUDITORY PROCESSING SKILLS

This test is designed to assess 4 major areas of central auditory processing skills. It consists of sub-tests that measure binaural separation, filtered speech perception, binaural fusion, and alternating speech perception. Each subtest is scored individually allowing the examiner to determine discrete and specific areas of difficulty. The Willeford will measure the performance of 5 year olds through adults and takes approximately 1 hour to administer in total. The test is designed to be administered by a trained professional in an audiometric suite with the use of earphones. The answer mode requires a verbal response and interpretation of message from the client.

D and Audiologist

WILSON VOICE PROFILE

Wilson Voice Profile is part of a kit that includes treatment and evaluation for voice disorders. The profile provides for information regarding hoarseness, pitch, resonance, and gives a scale for rating severity.

D

WOODCOCK-JOHNSON-SWASSING-BURKE CHECKLIST OF OBSERVABLE MODALITY STRENGTH CHARACTERISTICS

Information not available at this time.

WOODCOCK-JOHNSON PSYCHO-EDUCATIONAL BATTERY, BOOK 2

The test battery integrates tests of cognitive ability, learning aptitude, scholastic achievement, and interest level. Book 2 contains ten achievement tests and five interest-level tests. Response booklets accompany each book. Norms are based on a sample of over 4,000 subjects ranging from age three to 80 years and older. Extensive reliability and validity data are presented in the technical manual. All scores provided in the battery are cluster scores. Also for each individual subtest, grade equivalents, age equivalents, W-scores, percentile ranks and normal curve equivalents are available. Detailed examiner training instructions and structured page-by-page testing directions are provided.

A, B, C, D, E

WOODCOCK READING MASTERY TESTS

This is an individually administered battery of tests designed to assess skill development in the following five areas: letter identification, word identification, word attack, word comprehension, and passages comprehension. Two forms of the test are designed for students from kindergarten through grade 12. Results are combined to provide a composite index for overall reading skill. The mastery scale provides an index of a student's reading proficiency at different levels of difficulty. Diagnostic data that may help a classroom teacher pinpoint skill development strengths and weaknesses in order to plan a remedial program are provided by this test.

A, B, C, D, E

YELLOW BRICK ROAD

This test provides a comprehensive overview of learning aptitudes, scholastic achievement, cognitive ability, and interest level. Test results provide information for specific diagnostic procedures and instructional planning. Complete battery consists of twenty-seven tests divided into three major parts: cognitive ability, achievement, and interest level. To be used with students from age 3 to adult.

A, B, C, D, E

AAMD Adaptive Behavior Scales
American Association on Mental Deficiency

Adaptive Behavior Inventory for Children
The Psychological Corporation

Alpern-Boll Development Profile
Psychological Developmental Publications

Apraxia Battery for Adults
C. C. Publications, Inc.

Arizona Articulation Proficiency Scale - Revised
Western Psychological Services

Assessment of Basic Competencies
Scholastic Testing Service, Inc.

Assessment of Children's Language Comprehension
Consulting Psychologists Press, Inc.

Auditory Integrative Abilities Test
Educational Activities, Inc.

Auditory Pointing Test
Academic Therapy Publications

Autism Screening Instrument for Education Planning
Portland State University

Balthazar Scales for Adaptive Behavior for Profoundly and Severely Mentally Retarded
Research Press

Bankson Language Screening Test
University Park Press

Basic Concept Inventory
Follett Publishing Company

Bayley Scales of Infant Development
The Psychological Corporation

Bayley Scales of Mental Development
The Psychological Corporation

Bayley Scales of Motor Development
The Psychological Corporation

Behavior Problem Checklist
Children's Research Center

Bender Visual-Motor Gestalt Test
Western Psychological Services

Boehm Test of Basic Concepts
The Psychological Corporation

Botel Reading Inventory
Follett Educational Corporation

Bower-Lambert Scales for In-School Screening of Emotionally Disturbed Handicapped Children
Western Psychological Services

Brigance Diagnostic Inventory of Early Development

Bruininks-Oseretsky Test of Motor Proficiency
American Guidance Service

Burks' Behavior Rating Scales
Western Psychological Services

Cain-Levine Social Competency Scale
Consulting Psychologists Press, Inc.

California Achievement Tests
California Test Bureau

California Test of Mental Maturity
California Test Bureau

Callier Azusa Scale
Callier Center for Communication Disorders

Camelot Behavior Checklist
Edmark Associates

Carrow Elicited Language Inventory
Teaching Resources Corporation

Catell Infant Scale of Intelligence
The Psychological Corporation

Children's Voice Disorders

Clinical Evaluation of Language Functions-Diagnostic Battery
Charles E. Merrill Publishing Company

Clinical Voice Disorders: An Interdisciplinary Approach

Columbia Mental Maturity Test
Western Psychological Services

Communicative Evaluation Chart
Educators Publishing Service Inc.

Cooperative Sequential Test of Educational Progress
Educational Testing Service

Cratty Evaluation of Children's Movement Abilities
Educational Activities, Inc.

Denver Auditory Phoneme Sequencing Test
College-Hill Press

Denver Developmental Screening Test
Ladoca Project and Publishing Foundation

Detroit Tests of Learning Aptitude
The Bobbs-Merrill Education Publishing

Developmental Profile
Psychological Development Publications

Developmental Record

Developmental Test of Visual-Motor Integration
Follett Educational Corporation

Devereau Adolescent Behavior Rating Scale
Devereau Foundation

Devereau Child Behavior Rating Scale
Devereau Foundation

Devereau Elementary School Behavior Rating Scale
Devereau Foundation

Diagnostic Chart for Fundamental Processes in Arithmetic

Diagnostic Checklist for Behavior-Disturbed Children
Institute for Child Behavior Research

Diagnostic Reading Scales
California Test Bureau

Diagnostic Tests and Self-Helps in Arithmetic
California Test Bureau

Distinctive Feature Analysis of Misarticulations
University Park Press

Durrell Analysis of Reading Difficulty
Harcourt Brace Jovanovich, Inc.

Early Identification and Treatment of Learning Disabilities
Westinghouse Learning Corporation

Environmental Language Inventory
Charles E. Merrill Publishing Co.

Environmental Prelanguage Battery
Charles E. Merrill Publishing Co.

Fisher-Logemann Test of Articulation
Houghton Mifflin Company

Flowers Auditory Test of Selective Attention
Perceptual Learning Systems

Flowers-Costello Tests of Central Auditory Abilities
Perceptual Learning Systems

Fluency Assessment Battery

Fluharty Preschool Speech & Language Screening Test
Teaching Resources Corporation

Frostig Developmental Test of Visual Perception
Consulting Psychologists Press

Fullerton Language Test for Adolescents, Exp. ed.
Consulting Psychologists Press, Inc.

Gates-McKillop Reading Diagnostic Test
Teachers College Press

Gates-Russell Spelling Diagnostic Test
Teachers College Press

General Aptitude Test Battery
Employment Security Division

Gilmore Oral Reading Test
Harcourt Brace Jovanovich, Inc.

Goldman-Fristoe Test of Articulation
American Guidance Service, Inc.

Goldman-Fristoe-Woodcock Auditory Memory Tests
American Guidance Service, Inc.

Goldman-Fristoe-Woodcock Auditory Selective Attention Test
American Guidance Service, Inc.

Goldman-Fristoe-Woodcock Sound-Symbol Tests
American Guidance Service, Inc.

Goldman-Fristoe-Woodcock Test of Auditory Discrimination
American Guidance Service, Inc.

Goodenough-Harris Draw-A-Man Test
Harcourt Brace Jovanovich, Inc.

Grammatical Analysis of Elicited Language
Central Institute for the Deaf

Gray Oral Reading Test
The Bobbs-Merrill Company

Hahnemann High School Behavior Rating Scale

Hayes-Binet

Hiskey-Nebraska Test of Learning Aptitude
Marshall S. Hiskey

Houston Test for Language Development
Houston Press

Human Figures Drawing Test

Illinois Test of Psycholinguistic Abilities (ITPA)
University of Illinois Press or Western Psychological Services

Iowa Interest Inventory
Science Research Associates, Inc.

Iowa Pressure Articulation Test
Bureau of Educational Research and Service, Extension Division

Iowa Scale of Attitude Toward Stuttering
Interstate Printers and Publishers, Inc.

Key Math Diagnostic Arithmetic Test
American Guidance Service, Inc.

Kuhlman-Finch Scholastic Aptitude Test
American Guidance Service, Inc.

Language-Structured Auditory Retention Span Test
Academic Therapy Publications

Learning Accomplishment Profile (LAP)
Kaplan School Supply Corporation

Learning Accomplishment Profile for Infants
Kaplan School Supply Corporation

Leiter International Performance Scale
Western Psychological Services

Lincoln Diagnostic Spelling Test

Lincoln-Oseretsky Motor Development Scale
Western Psychological Services

Lindamood Auditory Conceptualization Test
Teaching Resources Corporation

Ling Phonetic Speech Evaluation
Alexander Graham Bell Publications

Louisville Behavior Checklist
Western Psychological Services

McCarthy Scales of Children's Abilities
The Psychological Corporation

McDonald Deep Test of Articulation
Stanwix House, Inc.

Meadow/Kendal Social-Emotional Assessment Inventory for Deaf Students
Gallaudet College, Kendal Green

Meeting Street School Screening Test
Meeting Street School

Merrill-Palmer Tests of Mental Abilities
Stoelting Company

Milanti-Comparetti Scales of Motor Development

Minnesota Preschool Scale
American Guidance Service, Inc.

Minnesota Test for Differential Diagnosis of Aphasia
University of Minnesota Press

Modern Techniques of Vocal Rehabilitation
Charles C. Thomas, Publisher

Motor-Free Test of Visual Perception
Academic Therapy Publications

Motor Speech Disorders
W. B. Saunders Co.

Northwestern Syntax Screening Test
Northwestern University Press

Ohio Tests of Articulation and Perception of Sounds
Stanwix House

Ordinal Scales of Psychological Development
University of Illinois Press

Osertsky Tests of Motor Proficiency
American Guidance Service, Inc.

Parental Diagnostic Questionnaire
Modern Education Corporation

Peabody Development Motor Scales
IMRID

Peabody Individual Achievement Test (PIAT)
American Guidance Service, Inc.

Peabody Picture Vocabulary Test - Revised
American Guidance Service, Inc.

Peterson and Quay Behavior Problem
H. Quay and D. Peterson

Photo Articulation Test
Academic Therapy Publications

Picture Story Language Test
Western Psychological Services

Porch Index of Communicative Ability in Children
Consulting Psychologists Press, Inc.

Predictive Screening Test of Articulation
Western Michigan University

Preschool Language Scale-Revised
Charles E. Merril Publishing Company

Procedures for the Phonological Analysis of Children's Language
University Park Press

Programmed Therapy for Stuttering In Children and Adults
Charles C. Thomas, Publisher

Psychoeducational Profile, in Text - Individualized Assessment and Treatment for Autistic and Developmentally Disabled Children (Volume I)
University Park Press

Pupil Behavior Inventory

Pupil Rating Scale
Grune and Stratton, Inc.

Purdue Perceptual Motor Survey
Charles E. Merrill Publishing Company

Reading Comprehension Battery for Aphasia
C. C. Publications, Inc.

Reading-Free Vocation Interest Inventory

Receptive-Expressive Emergent Language
Computer Management Corporation

Roughness Discrimination Test
American Printing House for the Blind

School and College Ability Test
Educational Testing Service

Screening Deep Test of Articulation
Stanwix House

Screening Test for Auditory Comprehension of Language
Teaching Resources Corporation

Screening Test for Developmental Apraxia of Speech
C. C. Publications, Inc.

Screening Test of Adolescent Language
University of Washington Press

Self Directed Search
Consulting Psychologists Press, Inc.

SKI-HI Language Developmental Scale and SKI-HI Receptive Language Test
Utah State University

Slingerland Screening Tests for Identifying Children with Specific Language Disability
Educator's Publishing Services

Slosson Intelligence Test
Slosson Educational Publications

Social and Prevocational Information Battery
California Test Bureau

Social and Prevocational Information Battery, Form T
California Test Bureau

Southern California Figure-Ground Perception Test
Western Psychological Services

Spellmaster: Spelling, Testing, and Evaluation

SRA Achievement Scales
Science Research Associates, Inc.

SRA Primary Mental Abilities Test
Science Research Associates

Stanford Achievement Test
Harcourt-Brace-Jovanovich, Inc.

Stanford-Binet Intelligence Scale
Houghton Mifflin Company

Stanford Diagnostic Arithmetic Test
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Stanford Function Developmental Assessment
Grune and Stratton

Stanford Test of Academic Skills

Structured Photographic Language Test
Janelle Publications

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C. C. Publications, Inc.

Stuttering Theory and Treatment
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Stuttering: Therapy for Children
Prentice-Hall, Inc.

Templin-Darley Tests of Articulation
Bureau of Educational Research and Service, Extension Division
The University of Iowa

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Teaching Resources Corporation

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Developmental Learning Materials

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Forework Publications

Test of Concept Utilization
Western Psychological Service

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Publishers Test Service

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Follett Educational Corporation

Test of Syntactic Abilities
Dormac, Inc.

Test of Written Language
Developmental Learning Materials

Test of Written Spelling

The Boone Voice Program for Children
C. C. Publications, Inc.

The Disfluent Child: A Management Program
University Park Press

The Fletcher Time by Count Test of Diadochokinetic Syllable Rate
C. C. Publications, Inc.

The Geist
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The Stocker Probe Technique
Modern Education Corporation

The Teaching Research Motor-Development Scale
Charles C. Thomas

The Testing-Teaching Module of Auditory Discrimination
Academic Therapy Publications

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Academic Therapy Publications

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Lingui Systems, Inc.

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Grune and Stratton, Inc.

Visual Efficiency Scale
American Printing House for the Blind

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Teaching Resources Corporation

Vocational Interests and Sophistication Assessment
Training and Research Center

Voice Problems of Children
Williams & Wilkins Co.

Walker Problem Behavior Identification Checklist

Washington Speech Sound Discrimination Test
Interstate Printers and Publishers, Inc.

Wechsler Adult Intelligence Scale (WAIS)
Psychological Corporation

Wechsler Adult Intelligence Scale - Revised (WAIS-R)
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Psychological Corporation

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Psychological Corporation

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Teaching Resources Corporation

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The Psychological Corporation

Wide Range Achievement Test (WRAT)
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Wide-Range Employment Sample Test
Guidance Associates of Delaware, Inc.

Wide Range Interest-Opinion Test (WRIOT)
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